

Faculty of Health Sciences

**Maintaining Emotional Wellbeing in the Intensive Care Unit: A
Grounded Theory Study from the Perspective of Experienced Nurses**

Joanne Marie Siffleet

**This thesis is presented for the Degree of
Master of Science
of
Curtin University**

March 2011

DECLARATION

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgment has been made.

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university.

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ABSTRACT

This Grounded Theory study developed a substantive theory to explore and explain the experienced nurse's perspective of maintaining emotional wellbeing in the Intensive Care Unit (ICU). Data were collected by recorded interviews of 15 experienced ICU registered nurses from an ICU of a metropolitan hospital in Perth, Western Australia. Emotional wellbeing was described by the participants as feelings of satisfaction and happiness, derived from the delivery of best care to patients and their families. This formed the context of the study. The core problem shared by ICU nurses was the *Inability to Protect Self from Distress*. Distress was described as feelings of grief, sadness, frustration and anger in response to caring for patients who were critically ill, and their families. Conditions were also identified that impacted the nurse's ability to protect self from distress: Best care; Autonomy; Teamwork; and Previous nursing and life experience. The Basic Social and Psychological Process used by nurses to protect themselves from distress, and therefore maintain their emotional wellbeing was called *Protecting Self from Distress*. The process was described under three phases: *Delivering best care*, *Validating care episodes*, and *Distancing self from distress*. The process described how nurses protected self from distress, including strategies to overcome or promote the conditions that impacted nurse wellbeing. Nurses maintain their emotional wellbeing through the delivery of best care. Best care referred to giving the best care possible given the nature of critical illness and limitations of critical care. Understanding the conditions that impacted nurse wellbeing provides valuable insight into factors that help or hinder the delivery of best care. The substantive theory outlined processes that enabled nurses to maintain their emotional wellbeing and succeed in providing best care to patients and families in the ICU. Minimising threats to the delivery of best care will promote nurse satisfaction, happiness, enhance wellbeing and may contribute to higher retention rates. The satisfaction and happiness enjoyed by nurses was found to be the reason the group in this study remained nursing in ICU.

ACKNOWLEDGEMENTS

The following are acknowledged and thanked for their valuable contribution to this thesis.

- All of the nurses who participated in this study.
- The current and past nursing staff of the Intensive Care Unit at Sir Charles Gairdner Hospital for their ongoing support and encouragement of this study.
- The Centre for Nursing Research, Innovation and Quality staff at Sir Charles Gairdner Hospital, in particular Ms Sue Davis for her support.
- Professor Anne Williams of Edith Cowan University (formerly of Curtin University) and the Centre for Nursing Research, Innovation and Quality at Sir Charles Gairdner Hospital for her continued support and direction as supervisor of this thesis.
- Dr Pat Rapley of Curtin University and the Centre for Nursing Research, Innovation and Quality at Sir Charles Gairdner Hospital for her assistance and support as associate supervisor.
- My friend, Sue Slatyer, for always being there as a guide and mentor.
- And finally, to Paul, James, Andrew and Louisa, for their patience and time.

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CHAPTER 1. INTRODUCTION

1.1 Background

It has been suggested that health is achieved by promoting physical health as well as emotional and social wellbeing (Stewart-Brown, 1998). The World Health Organization (1999) defines health as: 'a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity' (p.7). The inclusion of wellbeing as a health parameter by the World Health Organization gives worldwide recognition to the impact of emotional distress on physical disease and has been argued an important area of future health research (Stewart-Brown, 1998).

Emotional distress is encountered by most healthcare professionals, particularly those who frequently look after families in crisis, such as nurses who work in the Intensive Care Unit (ICU) (Sawatzky, 1996). Intensive care nurses work with patients who have complex needs in a highly technical environment. They are frequently confronted with trauma, suffering, sudden illness and death. The intensive care nurse, as part of a health care team, must also balance the care of the patient with the needs of the patient's family and friends (Harrison & Nixon, 2002; Hurst & Koplin-Baucum, 2005; Jezuit, 2003; Lindahl & Norberg, 2005).

Managing this dual focus is an important aspect in intensive care nursing and requires that nurses manage their own emotions. This may include recognising personal mortality and fear, as well as conflicting emotions such as moral discord, ambivalence and failure (Badger & O'Connor, 2006; Turnbull, Flabouris, & Iedema, 2005). Emotional distress or fatigue has been linked to feelings of burnout and a desire to leave intensive care nursing (Badger & O'Connor, 2006).

Australia benchmarks its healthcare against countries such as Canada, New Zealand and the United States all of whom are facing increasing demand on the limited resources of the nursing workforce (Williams, Chaboyer, & Patterson, 2003). In the United States, healthcare is the fastest-growing sector of the economy, and nursing is the largest work force within this sector (Choi, Bakken, Larson, Du, & Stone, 2004). There has also been a significant increase of specialty nursing areas such as critical care, dialysis units, maternity units, operating units and surgical wards with patients that are increasingly complex. Concomitantly, the proportion of part-time employment has increased from 36.3% in 1986 to 47.9% in 2008 (Australian Institute of health and Welfare, 2010). Also the nursing workforce is aging, with the average age of nurses in 2008 reported as 44.1 years, a steady

rise from 43.3 years in 2004 (Australian Institute of Health and Welfare, 2010). The proportion of nurses aged over 50 years has increased from 29.7% to 34.9% during the same period. Yet the number of specialty-trained nurses is below requirements and the gap appears to be widening (McVicar, 2003; Ruggerio, 2005).

In the current climate of a rapidly changing nursing workforce, attention should be on staff retention and examining the impact of work stresses on an individual's desire to remain in clinical practice. Current literature explores stressors and coping in this environment, but it does not fully describe factors associated with promoting the emotional wellbeing of intensive care nurses.

1.2 Literature Review

The British Medical Association published a report in 1967 on ICUs and noted that nursing staff working in this environment suffered emotional strain (cited in Crickmore, 1987). Interest in, and study of, the psychological demands on ICU staff, particularly nurses, became more defined in the 1970s when studies in this area focused on both the ICU environment and the inner experience and personal characteristics of the caregiver (Hay & Oaken, 1972; Tomlin, 1977). Stressors arising from the ICU environment have been identified, and whilst studies differed in their rank order of impact and intensity, they generally fell into one of four categories; patient care related, unit management issues, knowledge and skill deficiencies, and those associated with the physical work environment, including equipment (Hays, All, Mannahan, Cuaderes, Wallace, 2006; McVicar, 2003; Sawatzky, 1996; Yam & Shiu, 2003).

Any one of these stressors has been associated with emotional exhaustion and nurses wanting to leave ICU (Hays et al., 2006). Feelings of emotional exhaustion and reduced personal accomplishment were more likely in nurses who were inexperienced (Meltzer & Huckabay, 2004; Rashotte, 1997), in situations of inadequate staffing (Forest, 1999; Yam & Shui, 2007), or less than ideal group cohesion (DiMeglio, Padula, Piatek, Korber, Barret, Ducharme, et al., 2005). Emotional exhaustion and burnout presented as feelings of isolation and powerlessness, and have been described as challenging a person's perception of control over his or her environment and life outcomes (McClement & Degner, 1995; Cash, 1996; Forest, 1999; Meltzer & Huckabay, 2004;). These characteristics have also been identified and associated with critical incident stress, occurring after a particularly distressing event (Caine & Ter-Bagdasarian, 2003). In fact, some nurses working in this field have been described as experiencing post traumatic stress disorder (Sundin-Huard & Fahy, 1999; Tsay, Halstead, & McCrone, 2001). In an Australian qualitative study, Sundin-Huard

and Fahy (1999) identified feelings of moral distress and turmoil when caring for vulnerable patients in the ICU. These authors described vulnerable patients as those perceived as receiving inappropriate treatment.

The determining factors in the perception and interpretation of working in the ICU environment have been described as individual, influenced by the coping strategies of the nurse and the availability of adequate support systems (Badger & O'Connor, 2006; Crickmore, 1987; Sawatzky, 1996). Coping has to do with 'confronting events, either external or internal, by individuals or collectives, with varying degrees of success' (Keil, 2004, p664). Lazarus and Folkman (1984, p142) described the dynamics of coping as a process of changes in response to continuous appraisals and re-appraisals of the shifting person-environment relationship. Coping, as explained in *Roy's Adaptation Model*, is a dynamic process that includes both autonomic and unconscious responses (Roy & Andrews, 1999). Coping strategies in Roy's model may be driven by somatic, perceptual and cognitive modes and Remennick (2001) postulates that the resources of each individual varied according to individual circumstances, social conditions and personality type.

Personality types and coping resources have been investigated in studies with ICU nurses. Nurses who choose to work in ICU have been described as tolerant to stress (Maloney, 1983; Tummers, Merode, & Landeweerd, 2002) and more adventurous than most people (Maloney, 1983). Intensive care nurses have been identified as having personality constructs of hardiness such as commitment, accepting threats as challenges and wanting control over their own fate (Hurst & Koplin-Baucum 2005). Hurst and Koplin-Baucum (2005) gave 19 nurse participants who had worked in ICU for longer than 10 years a definition of hardiness to read and then asked them to describe factors in their working environment that promoted this characteristic. The study identified that the critical care nurses wanted to exhibit commitment, positive appraisal of demands and control over their environment.

Nurses who exhibited hardiness have also been reported as experiencing less stress and symptoms of burnout (Collins, 1996). Hardiness, first described by Kobasa and associates in 1979 (as cited in Lazarus & Folkman, 1984, p212), is recognised as the personal resources of one's ability to cope with stressors (Lazarus & Folkman, 1984). Yam and Shiu (2003) found that ICU nurses may have perceived stressors as both a threat and a challenge and interpretation was influenced by both personal characteristics, and what was happening in the work environment. This was a small quantitative study and the authors' conclusions were cautious as they believed that participants may have misunderstood the questionnaire. The study, conducted in Hong Kong, used a questionnaire translated from

English into Chinese. The authors believed that the intended meaning of the Likert-style questions was changed in translation and was not a culturally appropriate style of questionnaire for the participants (Yam & Shiu, 2003).

In addition to a sense of hardiness, there have been other factors identified as important for nurses working in demanding environments. Intensive care nurses described trying to find meaning in their work, even when it involved suffering and death (Badger, 2005). Nurses have also been reported as seeking a feeling of accomplishment resulting from being able to provide holistic care even when the outcomes were less than ideal (Halcombe, Daly, Jackson, & Davidson, 2004; Kirchoff, Spuhler, Walker, Hutton, & et al., 2000; Kociszewski, 2004). Nurses who had supportive social systems and developed positive workplace relationships with colleagues have reported fewer experiences of moral distress, stress and burnout (Rudy, 2001; Severinsson, 2003). Adaptive strategies such as talking to colleagues, mastery of technical tasks and being vigilant to discern and respond to signals that may have special meaning also led to less stress and frustration (Badger, 2005).

Some adaptive coping strategies however, whilst beneficial for the nurse, may have negative consequences for the patient and their family. Chesla (1996) found that some units had a culture that encouraged nurses to distance themselves from families and actively discouraged nurses from becoming 'involved' with patients and their families. Minimising family needs allowed nurses to treat patients as clinical problems (Cartledge, 2001; Holden, Harrison, & Johnson, 2002). Other nurses failed to see value in including families in the caring process and used multiple strategies to exclude them (Chesla, 1996; Holden, et al., 2002). McClement and Degner (1995) stated that nurses should 'risk' involvement and that this process allowed personal growth after reflection and preparation to meet such demands.

Work environments that were supportive of intensive care nursing practice were identified by intensive care nurses as supportive of autonomy, enabled control over their environment and had positive working relationships with colleagues (Chaboyer & Patterson, 2001; Choi, et al., 2004). Tummers et al. (2002) found no difference in actual autonomy, support or intrinsic work motivation between ICU nurses and non-ICU nurses. However, overall, lower levels of emotional exhaustion were also found in the ICU nurses, which the authors considered may be due to nurses selecting to work where they exhibited personality strengths. Tummers and colleagues postulated that ICU nurses were intrinsically able to work well in their environment but their study did not explore this concept further.

In summary, current literature does not explore health and emotional wellbeing in the ICU group of nurses and research that focuses on group or individual strengths could produce a shift toward understanding wellness and healthy functioning that may be beneficial to other nurses. Intensive care nursing continues to require a high degree of commitment and personal involvement. The continual advancement of technology and public expectations of a high standard of care means it is timely to explore the health and wellbeing of a vital workforce.

Empirical research to date is limited for several reasons. Firstly, many studies examined the reactions to stressors in the ICU and focused on emotional exhaustion and burnout. Secondly, it is difficult to theorise from existing literature that spans over three decades; a period of rapid change in both patient acuity and workforce characteristics. Thirdly, there is a need to focus on and learn from those nurses who have the capability of maintaining good health and emotional wellbeing in spite of constant exposure to suffering and to begin to explain this phenomenon to others.

1.3 Purpose and Significance

The aim of this study was to develop a substantive theory to explore and explain the experienced ICU nurse's perspective of maintaining emotional wellbeing in the Intensive Care Unit (ICU).

1.3.1 Research objectives

The following objectives guided the study:

- To explore and describe intensive care nurses' perceptions of emotional wellbeing in the ICU work environment.
- To explore and describe the experiences of intensive care nurses that impact either positively or negatively on their emotional wellbeing.
- To identify contexts and conditions that influence the emotional wellbeing of intensive care nurses.
- To develop a substantive theory that explains the nature and process of emotional wellbeing within the ICU work environment.

The findings of this study may be used as a guide for further research in both intensive care and other acute care areas. This study may assist nurses and managers in intensive care maintain and/or develop workplace conditions that are conducive to optimal health and emotional wellbeing of the staff who work there.

The significance of this research is to increase understanding of these complex phenomena and contribute to strategies aimed at supporting nurses within the context of ICU nursing in the WA health system. This is important in the current climate of nurse shortages brought on by the aging workforce and increasing demands for nursing services. Retaining nurses is vital. Identifying strategies and conditions that enhance wellbeing may also have applications for other acute care nurses within the WA health care system. A substantive theory explaining the process of maintaining emotional wellbeing from the nurses' perspective is detailed in this study. Implications for ICU nurses, nursing practice and directions for further research are provided.

1.4 Summary

This chapter has identified the importance of emotional wellbeing to health and described factors that put ICU nurses at risk of emotional exhaustion and burnout. Current literature has investigated stressors and coping responses in this group of nurses that partly explains how nurses may continue to work in this environment. However, making a link between the known stressors of ICU nursing and how nurses maintain their own wellbeing has not previously been identified in the literature. Chapter 2 describes the methodology used for this study.

CHAPTER 2. METHODOLOGY

2.1 Introduction

Chapter 2 describes the methodology of this study and outlines the procedural steps used to collect and analyse the data. Also discussed are the ethical aspects of this study and how trustworthiness and rigour issues were addressed.

2.2 Methodology

This study sought to understand how experienced ICU nurses continued working in the ICU given the frequency of exposure to distressed patients and families, and maintain their own emotional wellbeing. There is a paucity of literature investigating the subject of the emotional wellbeing of experienced ICU nurses. A qualitative methodology was chosen to explore and discover how this group of nurses maintained their emotional wellbeing.

Qualitative methodologies are used to investigate issues related to human behaviour which were developed within the social and behavioural sciences (Strauss & Corbin, 1998). Qualitative research uses analytic and interpretive processes to arrive at findings or theory, from data derived from sources such as interviews and observations (Strauss & Corbin, 1998). The qualitative methodology chosen for this study was Grounded Theory (Glaser & Strauss, 1967) to discover the processes nurses use to maintain their emotional wellbeing when working in the ICU and when confronted frequently with emotionally-distressing situations. The following paragraphs describe Grounded Theory in more detail.

2.2.1 Grounded Theory

Glaser and Strauss first introduced Grounded Theory in their book 'The Discovery of Grounded Theory' in 1967. This leading work challenged conventional research practice and proposed that theory could be generated from systematic qualitative analysis. The defining components of Glaser and Strauss's research procedures, the concurrent collection and analysis of data, introduced credibility to qualitative research that was unprecedented (Birks, Chapman & Francis, 2006; Charmaz, 2006).

Grounded Theory was developed by Glaser and Strauss with the intention of constructing abstract theoretical explanations of social processes (Charmaz, 2006). The finished Grounded Theory explains in new theoretical terms, the psychosocial process studied and also identifies the conditions under which the process varies or changes (Charmaz, 2006). Grounded Theory has been recognised as a useful method when no

existing theories were available (Stern, 1994, p116). The methods used to generate theory grounded in data were developed from complementary philosophical and theoretical view points. One of the suggested predominant influences, although not explicitly referred to by Glaser and Strauss (Moore, 2009), came from the writings of George Herbert Mead, summarised by Herbert Blumer (1967) in his essay on Symbolic Interactionism.

Symbolic Interactionism is a sociological perspective of human group life and human conduct (Blumer, 1967). This qualitative approach is based on the premise that meaning is derived from interaction with every object (tangible, social and abstract) that an individual encounters in their world. Furthermore, these meanings are modified by a process of interpretation used by a person when dealing with the things they encounter (Blumer, 1969).

Symbolic Interactionism differs from traditional beliefs such as realism, that meaning is intrinsic to the thing that has it, or that meaning is derived from the physical accretion of knowledge about objects. Blumer (1969) explained that Symbolic Interactionism views the meaning of objects as emanating from the ways in which other persons act toward the person with regard to the object. Therefore, the meanings of things are formed through social interaction and the use of the derived meaning occurred through a process of interpretation. It is central to the core belief of Symbolic Interactionism that the meanings that things have for a person are central in their own right (Blumer, 1969). Similarly, Grounded Theory was described by Glaser (1992) as examining 'the interrelationship between meaning in the perception of the subjects and their action' (p16).

In 1990, Grounded Theory diverged into two separate streams following the publication of the 'Basics of Qualitative Research' by Strauss and Corbin. Strauss and Corbin (1990) Grounded Theory methods included well-defined coding paradigms and procedures for analysis. This study was predominantly guided by the original method described by Glaser and Strauss (1967) but also used coding techniques described subsequently by Straus and Corbin (1990, 1998).

2.3 Setting

This study was undertaken in the ICU of a large metropolitan hospital in Perth, Western Australia. The then 18-bed ICU accepted elective and emergency surgical, medical, neurological, trauma and cardiothoracic patients. It is generally considered an adult facility ICU, but has accepted patients as young as 14 years from trauma and occasionally, younger patients for elective procedures. At the time of this study, the unit employed over 100 full-time equivalent registered nurses.

2.4 Sample Selection

Sandelowski (1993) stated that knowledge of the field being studied enhances the richness of the data collected. Personal experience of the phenomena being studied gives the researcher a comparative base to measure the range of meanings, and discover properties and dimensions from the data collected (Strauss & Corbin, 1998). Having theoretical sensitivity when collecting and analysing the data allows the researcher's experience to advance understanding. At the time of commencing the study proposal, the principal researcher, an ICU nurse, had worked in the study ICU for five years. At the time of data collection, the researcher was working in a nursing research centre at the study hospital and continued to work outside of the ICU during completion of the thesis. The sample for the study was drawn from the ICU and access to nurses was facilitated (following ethical approval) by the researcher's history of working in the ICU.

Purposive sampling was used to select and invite participants. This means that participants were selected because they had characteristics that were typical and representative of the phenomenon under investigation (Burns & Grove, 1997). The sample included 15 registered nurses who had a minimum of two years working in the study area. This period of time was considered in consultation with nurse managers in the area to represent experienced ICU nurses. It was considered that nurses who had been working in ICU for two years or more were experienced and had made a commitment to work in this area. Nurses were also selected to represent permanent full-time or part-time employment, and those that had chosen to work either eight-hour shift rostering patterns or 12-hour shift rostering patterns. It was important to focus on experienced ICU nurses as these nurses had demonstrated the desire and ability to remain working in this environment and that they were willing to share their experience of the phenomenon (Morse, 1989).

A colleague, known to the researcher was approached for a pilot interview. The first interview was conducted to develop interview technique as the researcher had limited interview experience prior to this. This interview was reviewed by the researcher and one of the supervisors, who had considerable experience in conducting interviews for qualitative research. The transcription of this interview was also reviewed by the supervisor to assess interview technique and assisted in refining the interview questions. This interview was not used in subsequent analysis.

Volunteers were sought initially at staff meetings, education sessions and personal contact within the ICU. Each nurse who attended an education session or approached

personally was given an information sheet (Appendix A) about the study that included contact details of the principal researcher. This was undertaken over a period of four weeks and resulted in four volunteers.

The first four volunteers were interviewed and initial analysis revealed emerging concepts that were used to guide theoretical sampling (Glaser and Strauss, 1967). Theoretical sampling, which is 'sampling on the basis of concepts that have proven theoretical relevance to the evolving theory' (Strauss & Corbin, 1998, p176), was used to invite further participants. This meant that participants were sought according to their knowledge of the research topic and continued until theoretical saturation was achieved (Glaser and Strauss, 1967). Theoretical saturation was established by the identification of dense categories and the absence of new concepts in the data (Strauss and Corbin, 1990). In other words, saturation was recognised when no new properties, dimensions, relationships, conditions, actions/interactions or consequences emerged from the data (Strauss & Corbin, 1998, p137). Charmaz (2006) described the common understanding of saturation in Grounded Theory as 'I kept finding the same patterns' (p113).

Further nurse participants were identified by the researcher in collaboration with the nurse manager and approached personally by the researcher. Nurses who were approached were asked if they were willing to participate in the study and given time to consider their answer. Six nurses who were approached declined to participate and the remaining eleven participants interviewed were recruited this way.

2.5 Ethical Considerations

This study was given approval by the Human Research Ethics Committee of Curtin University and the Human Research Ethics Committee at the study hospital. All participants were informed of the purpose of the study verbally and in writing. The written information (Appendix A) outlined the purpose of the study, the voluntary nature of participation, the right to withdraw at anytime without penalty, as well as assurance that all information provided would be non-identifiable, confidential and kept in a locked filing cabinet within the researcher's locked office, and accessed by the principal researcher only. Participants were given time to consider their participation and given the opportunity to ask questions. All participants were made aware when initially approached about the study and again just prior to the interview commencing that interviews would be recorded and transcribed verbatim. Once participants were satisfied with the requirements of the study, a consent form (Appendix B) was signed.

Access to data collected was limited to the researcher and supervisors. All interviews except for three were digitally recorded and transcribed verbatim by the principal investigator (PI). Transcriptions from the digital files were checked for accuracy by listening and amending as necessary. Three of the interviews were recorded on a tape-recorder and transcribed by a secretary who had been informed of the confidential nature of the data. The PI listened to the tape recordings and checked these transcripts for accuracy. Participants' full names were not used throughout the recordings. Digital recordings were stored on a password-protected computer accessed by the PI only. Tapes were stored in a locked filing cabinet in a locked office. All data was de-identified using a random numeric code generated by the researcher. The master list containing identifying information and corresponding codes were stored in a locked filing cabinet, accessed by the PI only and kept separate to the transcriptions. Names of participants were not transcribed. Tapes, digital recordings, transcriptions of the interviews, consent forms, demographics and memos will be archived and kept for a further five years from the publication of the study to comply with the guidelines under Section 3 of the Joint National Health and Medical Research Council/Australian Vice Chancellors' Committee Statement and Guidelines on Research Practice (NHMRC, 2007).

2.6 Procedure

Data were collected through audio-recorded interviews guided by semi-structured questions, developed to explore the objectives of the study (Appendix C). Interviews were conducted in private settings with minimal risk of interruption. All participants were given the choice of where they were most comfortable being interviewed (Charmaz, 2006). Five came to the researcher's home, three were interviewed in their own home and the remaining seven were conducted in private offices within the study hospital.

Interviews conducted at either the participant's or researcher's home were set at times when privacy could be assured, comfortable seating and speaking positions were set up and interruptions were minimal. Interviews at the study hospital were conducted in small offices away from the clinical setting. Signs were put outside the door to deter interruptions. Some interruptions occurred at all interview locations, and in each instance the researcher re-focused the interviewee by repeating what had just been said or by repeating the question.

Each interview began with informal chat as each participant was known to the researcher. The length of time for the informal chat varied and continued until the researcher felt the participant was comfortable to proceed to interview. The researcher

then introduced the research and explained its purpose. Each participant was then asked to complete a consent form (Appendix B) and encouraged to ask any questions. Demographic data (Appendix D) was also collected and participants were reminded that they were free to interrupt the interview if they felt they needed to stop for any reason. None of the participants requested to stop an interview. Three of the participants were followed up informally after the interview to clarify information for emerging categories (Glaser, 1998) and one participant contacted the researcher via e-mail to provide some further details.

Interviews were conducted using a narrative approach, in the form of an informal conversational interview (Mishler, 1986). Semi-structured open ended questions (Appendix C) were used that were developed using the study objectives as a guide. Questions were further refined following the first interview. Each interview was different in format as the researcher was guided by the responses of the participant. The researcher listened for points of interest to the study that occurred in the responses given by the interviewee. The researcher then phrased questions based on what had been said by the participant to explore emerging themes and expressed experience of the participant. The interview technique allowed exploration of experiences by using words such as 'how', 'what', 'when', 'where' and 'can you please explain that' to facilitate exploration of the topic (Charmaz, 2006).

Each topic that arose during the interview was explored in full before moving to the next topic using the interview guide. When following the interview guide the researcher was flexible in her approach. For example, a topic may have been covered in a previous answer by the participant, therefore questions that had already been answered may have been omitted. Questions may also have been asked out of order, depending on the flow and direction of previous answers by the participant.

Notes as required were also taken throughout the interview to capture thoughts and write prompts for the researcher to explore ideas introduced by the participant throughout the interview. The notes written throughout the interview were used in two ways; firstly, a particular word may have been used to describe an emotion or situation and the researcher might note the word. Once the participant had completed the response to a question, the interviewer would ask the participant to expand on the word used for the situation. Secondly, memos taken by the researcher were also referred to throughout the analysis to capture thoughts of the researcher as they occurred about the individual incidents in the data. The use of note taking was explained to participants prior to the commencement of the interview. The use of memo writing throughout an interview was used to allow the participant to respond fully to each question without interruption to clarify meanings until

there was a natural pause in the discussion. Memos were made throughout transcription and checking of transcriptions to capture any impressions or leads to pursue in subsequent interviews (Strauss & Corbin, 1998).

Memo notes were kept and referred to throughout analysis to check categories and dimensions (Strauss & Corbin, 1998). At times, sections of interviews were also checked to confirm interpretation of context and meaning. The first stages of analysis commenced at the end of interview five and developed through subsequent interviews.

2.7 Data Analysis

Data were organised and managed for analysis using QSR NVivo, version 7 (QSR International, Pty. Ltd., 2006). Data were simultaneously collected, coded and analysed using the constant comparative method as described by (Glaser & Strauss, 1967) to allow exploration and theory development. This method involved initially coding the data to identify as many categories as possible. Following that, incidents across the data were compared to find patterns and begin to order categories. This was achieved by subsuming some categories into higher order categories and a higher level of conceptualisation emerged. Categories continued to evolve and theoretical properties defined by the researcher searching for incidents in the data that were applicable to each category. This continued until theoretical saturation was achieved. Given the time required for this method, the interviews were conducted over a 12-month period (May 2007–April 2008). The coding procedures utilised in the Grounded Theory method involve three levels of coding: open; axial; and selective (Strauss & Corbin, 1998).

2.7.1 Constant comparative method and asking questions

Chen and Boore (2009) argued that the two most essential operations throughout the analysis procedures in Grounded Theory were asking questions and making theoretical comparisons. Throughout the coding process, the researcher explored the data continually to identify what is actually happening. For each incident, the researcher seeks to explore which category or dimension it fits into and how (Chen & Boore, 2009). This process of interrogation includes constantly making theoretical comparisons within the data to discover the basic social and psychological problems faced by the participants and the processes used to overcome them to make life workable (Glaser, 1998). Throughout the data analysis, the researcher is constantly checking for new categories or properties and reviewing, reintegrating and refining theoretical notions as the theory emerges and is articulated (Glaser & Strauss, 1967). To build the substantive theory, identifying the process

through the analytic procedures described is essential to represent the dynamic nature of action and interaction derived from the data (Strauss & Corbin, 1998).

2.7.2 Open coding

In Grounded Theory, coding reduces the data to segments and then puts the data back together again. It is the central process by which theories are built from the data (Strauss & Corbin, 1998). The interviews were coded line by line, sentence by sentence, in a process called Open Coding (Strauss & Corbin, 1998) to identify common themes and categories. In this way, the data were broken down to specific segments of data and coded as an abstraction or concept. The process of open coding opened up the texts to discover the thoughts and meanings contained within. Each concept discovered was labelled and was an abstract representation of an event or phenomena. The labelled segments of data were then examined and compared to facilitate conceptualising and categorizing of the data.

Initially, 72 codes emerged and were used to represent the categories and sub-categories in the data (Appendix E). Some of the codes identified from the data were collapsed and others expanded resulting in nine major categories and 70 sub-categories. The major categories were mapped onto the interview scripts using coloured lines to note the position of each code using NVivo version 7. This software facilitated the grouping of each category and each coded segment was compared with other segments representing the same category. The data were then examined in more detail.

2.7.3 Axial coding

Axial Coding was used to reconnect the data by making connections between the core categories, or major themes that emerged and subcategories. The purpose of axial coding is to begin reassembling the data, linking categories to sub-categories in a way that will describe and explain the phenomena more precisely (Strauss & Corbin, 1998). Categories or phenomena that have been identified represent an issue or happening that has been defined by the participants as important. Sub-categories represent a greater explanation of the category and answer questions such as when, where, how, who, why and with what. Table 2.1 exemplifies coding for the category Teamwork and the memos and sub-categories used for coding. Categories, sub-categories and the relationships between them emerge as coding proceeds through the stages (Strauss & Corbin, 1998).

Throughout the process of Axial Coding, transcripts were continually referred to and proposed conditions identified were confirmed by finding examples of both positive and negative cases. Open Coding continued in conjunction with Axial Coding on existing and

subsequent interviews to develop categories already identified and look for new properties and dimensions. Both dimensions and relationships continued to emerge from the data until saturation was achieved.

2.7.4 Selective coding

The final stage of coding, known as Selective Coding was undertaken. Selective Coding is a process of identification and integration of core categories or major themes discovered in the data. This conceptual stage expanded on the relationships between the categories, explored the dimensions and validated the connections (Strauss & Corbin, 1998). Selective Coding is a process where the analyst interacts with the data and theory development and refinement occurs. Analysis through Selective Coding revealed the core category that was central to the developing theory. Distress was identified as the central theme and the substantive theory that nurses protected themselves from distress to maintain their emotional wellbeing was derived and called *Protecting Self from Distress*.

2.7.5 Format of findings

The emerging theory from the findings has been formatted and described as The Basic Social and Psychological Problem and The Basic Social and Psychological Process. The contexts and conditions that influence The Basic Social and Psychological Problem and Process are also reported.

Table 2.1 Teamwork: example of a major category and memos developed to sort data into relevant sub-categories to discover relationships.

TEAMWORK		
Sub-category		Memo
Context	Referred to the background condition under which actions/interactions were taken	<ul style="list-style-type: none"> • How do nurses define teamwork? • How does teamwork function in ICU? • What are the rules of the team? • Who is in the team? • What roles are in the team?
Causal conditions	The events or variables that lead to the development of the phenomena, i.e. when something within the context of teamwork led nurses to experience distress	<ul style="list-style-type: none"> • What undermines teamwork? • How do nurses feel when teamwork is not evident? • What happens when someone is not a team player? • What does teamwork give individual nurses (i.e. support)? • Does the role of the nurse, i.e. coordinator, patient care, admissions nurse affect their perception of other nurses in relation to teamwork?
Intervening conditions	Specific properties and dimensions of teamwork which facilitated nurses feeling protected from distress	<ul style="list-style-type: none"> • What characteristics of a nurse enhances their team membership? • When is teamwork important, what situations arise where teamwork is vital? • How does socialising/fun enhance teamwork? • How does the condition of the patient/family affect teamwork? • What influence do other health care professionals have on teamwork? • How does behaviour of other nurses affect individuals in the team?
Strategies	Purposeful actions that nurses did in response to the causal conditions, intervening conditions or phenomena	<ul style="list-style-type: none"> • What do nurses do when teamwork is failing? • What do nurses do when they feel distressed because they were not supported? • What do nurses do when the actions of others cause them frustration?
Consequences	The consequences or outcomes of the strategies used by the nurse in relation to teamwork were seen to impact the emotional wellbeing of the nurse and whether they felt in the team or out of the team	<ul style="list-style-type: none"> • Nurses felt supported and able to continue working if teamwork was functional • Experience helped nurses develop a teamwork ethic • Patient care was enhanced by functioning teamwork • Feelings of personal achievement were enhanced by teamwork

2.8 Trustworthiness and Rigour

Trustworthiness and rigour in qualitative research are determined by the congruence with the philosophical perspective of the study as well as openness and thoroughness in data collection (Burns & Grove, 1997). The trustworthiness of the model presented is upheld if those that lived the phenomena can see their own reality mirrored in the findings. To avoid bias in data collection, the researcher was careful to avoid the introduction of preconceptions by basing interviews on open-ended questions developed prior to commencing, and tangents followed only once they were introduced by the study participants. Strategies that were incorporated into the design that ensured results were truthful and represented the phenomena under investigation included:

- Describing the process of data collection and analysis in detail to facilitate critique and replication
- Checking interview transcripts for accuracy
- A review of interview transcripts by an independent researcher to identify introduction of researcher bias
- Confirmation of codes and categories by giving segments of transcripts to other researchers for checking.

Descriptions of provisional findings were given to sample participants during the analysis period for verification that the findings made sense in terms of their personal experience. Participants were invited to read the summary and comment in any way they wished, including any thoughts or comments and whether they agreed or disagreed with the summary of findings. All responses affirmed that the findings represented their personal experience. Finally, a summary of the results was given to three non-participant nurses to validate the findings. This has been described as a strategy to test credibility and a way of assuring validity (Guba & Lincoln, 1981).

The participants and non-participants who were asked to review the summary of findings agreed with the content. The comments were positive and nurses confirmed that the summary represented their lived experience.

2.9 Summary of Research Methodology

Grounded Theory was used to explore and describe the process used by ICU nurses to maintain their emotional wellbeing. Data analysis revealed the actions, interactions, and factors related to nurses and their emotional wellbeing. This led to the development of a

substantive theory which explained the process nurses used to maintain their emotional wellbeing working in the ICU.

2.10 Preface to Results

The findings of this study will be presented in the following three chapters. Chapter 3 describes the context of emotional wellbeing in ICU. Chapter 4 discusses the *Basic Psychological Problem* and the conditions under which this occurs, identified from the interviews as common to this group of nurses. This is followed by a discussion in Chapter 5 of the *Basic Social and Psychological Process*, which is the theory constructed from the data on how the nurses in this study manage the basic social and psychological problem.

Throughout the results, direct quotes are used to illustrate the findings. Within the quotes where the meaning of a word or phrase may be unclear for the reader, information or words within brackets (like this) were added by the researcher to facilitate understanding for the reader.

CHAPTER 3. THE CONTEXT OF EMOTIONAL WELLBEING

3.1 Introduction

The purpose of this Grounded Theory study was to explore and describe how experienced ICU nurses maintain their emotional wellbeing. In order to gain an understanding of the phenomenon under investigation, this chapter describes the context of emotional wellbeing in ICU. This description was derived from the data, specifically, nurses were asked to identify the meaning of emotional wellbeing within the context of working in the ICU.

This chapter commences with the demographic data of the nurses interviewed. Emotional wellbeing is discussed with a description of the emotional responses in ICU that nurses attribute to supporting their wellbeing and forms the context of this study. The dominant finding in analysing texts relating to emotional wellbeing was the direct relationship between the success of the nurse delivering best care and feelings of happiness and satisfaction. The last section of this chapter describes the conditions, including best care that is beneficial to the nurses' emotional wellbeing.

3.2 Sample Description

Fifteen registered nurses were interviewed, 12 (80%) were female, three (20%) were male and the average age was 39.4 years (range=26 to 50 years). The length of time working in the ICU ranged between three and 25 years with a mean of 13 years. Respondents also indicated the total length of time nursing and the mean was 18.6 years (range=5 to 33 years). There were eight nurses currently employed as Clinical Nurses (level two registered nurses recognised as clinically competent in their field of nursing) and seven were registered nurses (two of whom have worked as Clinical Nurses in ICU previously) (see Table 3.1). Six nurses undertook a hospital-based training program as part of their initial training, the remainder qualified through university-based education. Fourteen nurses held either a critical care certificate or postgraduate certificate in critical care nursing. One nurse was currently studying for a postgraduate qualification in critical care nursing.

Table 3.1 Demographic Information of the participants (n=15)

Age: Mean (range) in years	39.4 (26–50)
Gender:	
Female	12
Male	3
Years Nursing: Mean (range)	19 (5–33)
Years ICU: Mean (range)	13 (3–25)
12 hour shift roster	8
Full time	4
Part time	4
8 hour shift roster	7
Full time	1
Part time	6
Clinical Nurse (Level 2 RN)	8
Registered Nurse (Level 1 RN)	7
Intend to stay nursing in ICU	15

3.3 Emotional Wellbeing: the Positive Emotional Impact of Nursing in ICU

Nurses described the context of emotional wellbeing working in the ICU as feelings of happiness, enjoyment and personal satisfaction. These feelings were experienced predominantly when nurses felt that they had done their best working with critically-ill patients and their families. It was evident from the data that the source of happiness and personal satisfaction for nurses was the successful delivery of best care to patients and their families. Nurses also stated that when they experienced feelings of happiness and personal satisfaction, they were motivated to continue working in the ICU.

3.3.1 Happiness

The context of emotional wellbeing was the positive emotional impact nurses experienced when working in the ICU. They commonly used words such as happiness and enjoyment to depict their feelings. For experienced nurses, most of the time, the experience of working in the ICU was happy and rewarding:

It's great, you know you have a good day at work and you are just enjoying what you are doing. You are getting more back from what you are doing and from your colleagues as well. Everything seems to run more smoothly when you are having a

good day, and you go home and you know you just feel happy and cheerful. You find you don't think about work once you're home, you just take home nice feelings. (N7)

Most participants described emotional wellbeing in terms of general happiness. Happiness was derived from achievement and fulfilment as an ICU nurse that included working effectively within a team:

Emotional wellbeing for me is probably leaving a shift and feeling that I have actually done something fulfilling. I've not gone backwards and I have supported the people working round about me and had team ethic (sic) and team building there. (N11)

The context of emotional wellbeing was also described as mental health and how it impacted work performance. Nurses sought feelings of emotional wellbeing and reflected on their emotional responses at work:

I think emotional wellbeing of intensive care nurses is your mental health while you are at work, your mental stability. I suppose a lot of it comes down to your happiness like that plays a little bit into your wellbeing. But for me I look at how happy I am at work, what affects my mood, what could have triggered me into making me angry or frustrated. (N4)

The context of emotional wellbeing was a feeling of wellness that was central to coping and managing the events of daily living: *'It just means your general happiness, how you cope with things and how happy you are'* (N5). Concepts such as stability and balance were used frequently when talking about emotional wellbeing:

I think mostly emotional wellbeing would mean balance, and being able to cope with daily stresses in life, without it being a big issue and without it being a big deal to you. . . . I think it is balance in life and being able to cope with stress. (N15)

The nurses interviewed perceived the ICU work environment as an ideal area to work in and that was a significant factor in their perceptions of emotional wellbeing:

I don't find it hard in intensive care, the physical and emotional part; I think it would be really hard on the ward, caring for patients, really hard. And if you took me out of the ICU environment (pause) that would probably put my stress levels right up, if you put me on the ward. Yes so I think I will stick to intensive care, it is what I know best. So I like the good things, I like getting told I am doing a good job in intensive care and that if you put me on one of the wards, I don't think I am going to get that an awful lot. That is why I stay in ICU. (N14)

The ICU environment was identified as an area where the nurses interviewed could experience emotional wellbeing through their work. Nursing in ICU was described as very rewarding and it was evident that nurses experienced a sense of achievement that had a

positive impact on emotional wellbeing. As described by one nurse, the positive impact derived from returning to ICU nursing after a period of extended leave was immense:

I went back to do a casual shift after (extended leave), I was starting to get a bit fidgety at home, 4 months I went 'right, I need to do a casual shift' and I came home from that six hours a completely different person. I was so, so happy (emotional) and so excited that my (partner) went 'oh my God you should go back to work more often'. So I obviously get a lot out of work. I don't know why but I feel a sense of accomplishment and if I wasn't having that sense of accomplishment I wouldn't be happy. (N2)

The data also revealed a long-term commitment to work in the ICU from those interviewed and this was attributed to the love and enjoyment of work:

I do enjoy it really. I mean, it sounds awful, I come to work and I like what I do. I don't think I would still be doing it after that length of time if I didn't. I do like what I do, I enjoy my job and given my time again I don't think I would not do anything differently actually. I do enjoy the day to day. (N7)

Happiness was evident throughout descriptions of emotional wellbeing and was directly linked to caring for patients who were critically ill. Nurses derived personal satisfaction from caring for critically-ill patients in the ICU.

3.3.2 Personal satisfaction

Working in ICU provided personal reward for nurses and fulfilling the ICU nursing role was a major contributor to nurses and their emotional wellbeing. Personal satisfaction was derived directly from caring for the patient's physical, emotional and spiritual needs to the best of their ability:

So that is big for me, my satisfaction is all of those things coming together and to know I can walk away from this shift and know that I've covered all my bases. I've looked at that lady and I know she's septic, and she is on inotropes (vaso-active drug). I've sorted out her nor-adrenaline, I've given her fluids, I've done my ABC, I have done everything. I've been on the ball with the bloods; I have instigated dialysis or whatever (N12)

The participants in this study stated that ICU nursing presented opportunities to provide thorough nursing care. Nurses further qualified that the personal satisfaction they felt came from a sense of fulfilment in their own expectations of delivering best care for the patient. One nurse stated:

You feel like you are using all of you nursing skills whether it be even something simple as just washing or cleaning, just for that one patient, you know that you are doing everything that you can. . . . I enjoy just knowing that I've tried everything I could to get them comfortable . . . they haven't had their hair washed, just to do that even. . . . It is nice to know you have got a bit of extra time. I hate the shift where you. . . . you have to do just the essentials. I like to

know that you can do that little bit more, like even brush their teeth. . . . But it is nice if you have been able to do everything that you have wanted to that shift. . . . I feel more of a nurse. (N8)

Nurses made comparisons between their experiences of ward nursing and believed that ICU nursing provided greater opportunities for personal satisfaction. Being able to give complete care was satisfying and contrasted with their own experiences of frustration on busy wards:

I can always go home and not feel any guilt . . . I remember on the wards thinking 'oh you're spending your whole day running and of my five patients I only showered three of them, and two of them I flicked a urine bottle and jammed pills down the rest of everybody else's throat, and I did one dressing'. . . . I hadn't stopped, I was sweating (laughs) so I enjoy knowing everything has been done for my patient, no stone is left unturned, that I am thorough. (N4)

Intensive care nursing was described as a vocation and those interviewed demonstrated a dedication to help people and see patients come through ICU. The reward for nurses was attributed to being able to give best nursing care. Nurses experienced a sense of productivity that was good for their own wellbeing:

Because I really love the job, I really like nursing. . . . I think that I'm an old fashioned nurse, you know (number) years on the job. I really enjoy the basic nursing. . . . I like making them comfortable and clean plus I enjoy ICU nursing because it is exciting. . . . It's productive when people really do get better . . . you get them in on the ward for their gout and they go home and still have gout. They really get better in ICU so it is satisfying, really satisfying. (N5)

The ICU environment was identified as providing the opportunities for nurses to fulfil their role which was rewarding for those interviewed. Personal satisfaction contributed directly to a state of wellbeing.

3.3.3 Summary: context of emotional wellbeing

The context of emotional wellbeing from the experienced ICU nurses' perspective has been described. Within the context of emotional wellbeing, nurses experienced happiness, personal satisfaction and enjoyed working in ICU. Nurses acknowledged that emotional wellbeing was a sense of balance that enabled them to work in ICU and provide best care for patients. For these nurses, experiences of happiness and satisfaction motivated them to want to continue working in the ICU.

3.4 Conditions: Positive Impact on Emotional Wellbeing

The data revealed that there were circumstances or incidents that enhanced the ability of the nurse to experience happiness and satisfaction from their work. These incidents were

grouped together and explored for their properties and dimensions. The themes that emerged represent conditions that were beneficial to nurse wellbeing. The conditions identified were: the delivery of best care to patients and their families; the ability to work autonomously; support from a teamwork environment and previous nursing and life experience.

3.4.1 Best care

The achievement of delivering best care to patients and their families created feelings of emotional wellbeing for nurses. The condition of *Best Care* was inclusive of caring for patients and their families. It occurred when nurses determined that they had done their best in providing care to critically-ill patients. Best care meant that the best was done for the patient and their family within the circumstances of their illness. Nurses sought to achieve the best that any nurse, working with the multidisciplinary team, could have done in the same circumstances. The nurses interviewed were experienced practitioners who used their skills to care for patients and doing this successfully was fulfilling and satisfying. Best care was holistic, and whilst nurses stated that they cared for the complex physiological needs of the patient, the focus was often on basic needs of the patient and the emotional care of the family. Nurses identified their role within the title, Intensive Care Unit, stressing the importance of intensive caring:

. . . We are working in an intensive care unit, not an intensive medicine unit, or an intensive science unit. It is a care unit (long pause) that level of care is obviously really important, right from the technology we use, right down to the intimacy of (long pause) what we do to patients and you know how involved you can potentially get with them at such a trying time. (N10)

Nurses spoke of the physical, emotional and technological care of the patients and how they saw balancing these aspects of care as important. In this study, best care was determined by the nurse as being what was best for the patient and their family at that time. Setting goals that were individually patient and family-focused was important. Descriptions also emerged of how nurses integrated both physical and emotional cues to determine their nursing care. One nurse summarised how they understood the ICU nursing role:

My role is as a carer. . . . You look after people physically, mentally and spiritually and if you do the three, then you balance it out. . . . Sometimes you can't do any more for the patient from a physical perspective, you can just tidy their hair or do something, because that is what the family remember, they are the small touches. From a mental perspective, a lot of them are unconscious but you would like to know that they are not in any pain. . . . If there are any big conversations to be

had that they are not overhearing stuff that they shouldn't and that they are not fearful. You try and read their tachycardia and their hypotension and all these things. . . . From the spiritual perspective . . . might be for family, you can get them the chaplaincy or whatever the department they want. . . . But there is another side to the spiritual side that the family won't ask and they won't if they are fearful or they won't say . . . you can just bring it up and it will happen, it always flows, you just start it up and all they want is for someone to just open the door. (N6)

Nurses acknowledged that their role was special and a privilege. Exploring the full role of the nurse within this study demonstrated instances of how nurses perceived satisfaction and interpreted the care of patients as a benefit to themselves:

I think in nursing . . . you meet somebody, you shake hands with them out in public and you only know what that facade is there. When you are in a hospital and somebody is sick they allow you to go that extra space that they won't allow outside in the community. So it is actually a privilege because you are actually allowed to do that, people are opening themselves a little bit more to you. It is a job where there is that little extra if you choose to allow it to happen. That is there and you can actually utilise that to the benefit of the patient and yourself. (N6)

The psychosocial care of families was also important and nurses in ICU described the delivery of best care as *'it comes together with the patient care, what that patient needs and then a relationship with the family as well.'* (N9) One nurse put best care into context with the satisfaction nurses experienced from giving complete care:

Encouraging them (relatives) to get involved. . . . It's not about making the patients better, it's not about or having a parallel bed with all the sheets and blankets all neat and tidy, it's about the satisfaction from having done a good job and achieving my goals. (N3)

Caring for patients at the end of life was also an opportunity for nurses to experience a personal benefit. Nurses strived to provide the best end-of-life care and to offer the family of the dying patient the best care. As described in the following exemplar, nurses felt privileged caring for patients throughout the full spectrum of illness, including when patients were dying in ICU, and nurses valued the impact they could make at this time:

It is more where you feel you have made the most impact or connection with the family even in the simple moments but intensive care is an area where things are extreme. They either are as bad as they can get. . . . Being able to help support that family or the patient in that situation, at the extreme of their life is pretty honourable and I don't think that you can match that anywhere, to that intensity anyway, anywhere else. (N10)

When nurses achieved their goals, they felt good about their care and good about themselves. Nurses strived to have experiences of delivering best care because it had a

clearly-defined positive effect on their emotional wellbeing. The desire to work for happiness was further explained as: *'I need a little bit more. I need something personal, personal satisfaction, something I have achieved myself that has nothing to do with my family or friends.'* (N2) The dedication and love for working in ICU was summarised in the following exemplar:

I'm completely not ready to leave ICU, I still love my work and I still love the complexity of the patients and I enjoy thinking and I still enjoy learning. So for me it's about looking after those patients, looking after the relatives, making a difference. Whether it's telling a father, a husband to bring in baby photos of the newborn baby while his wife is lying there critically ill, little tiny things can put a smile on their face. Allow them a little bit of time, time to just sit, time to be still, time to not have to talk. To look after these critically ill people when they come in, then be able to achieve my goals for the day. I still love coming to work. Completely mental! I still love coming to work. (N3)

Nurses stated specifically that they enjoyed working in the ICU and caring for the unconscious patient and their families. The achievement of best care provided nurses both happiness and satisfaction from their work. The drive to have positive experiences of caring for critical care patients was described by those interviewed and was a strong motivation to keep working in the ICU.

3.4.1.1 Caring for the patient's family

Caring for families was described as integral to caring for the patient and often, the focus of care became the families themselves. Delivering best care to families was equally rewarding for nurses. Recognising the needs of the family and assisting them throughout their relatives' illness was a vital element of caring for the patient. Nurses monitored the family closely for signs of stress and anxiety, seeking ways to minimise distress:

You can really give something to families as much as the patient, because their needs are so great. The patient is unconscious, I mean you do everything for them, but if they are really ill and they are not going to get better . . . in that situation, to be able to help the family, give them the explanations they need, get the people to talk to them that they need to talk to, and just help take that part of the anxiety. (N7)

Minimising distress and assisting families manage their emotional reactions was enabling for the nurse and facilitated their care. Families were described as needing guidance on how to respond to their very sick relative and to be allowed to connect in a small positive way, albeit most often for the last moments of the patient's life. One nurse described situations where nurses actively sought to engage the family and enable them to connect with their sick or dying relative:

It's often good when they (the family) get the information that they really need explained in a way that they really understand, and that is the biggest thing in intensive care. The other things that families need is discussions with hope and usually medical staff are quite good at taking all that away from families and it is their job. They have to be able to explain all the bad things, but when they do I often find that there is often nothing left for them. . . . usually if I see that, though, I usually maybe touch on a subject, their loved ones are here, they are still alive, although be it they're critically ill. . . . Maybe we should just work with that and it is the hope thing. . . . Often they have lost control, they haven't got any control, but if they have got the hope thing left, then it is something that they can think and hang on to. (N14)

Developing relationships with families was often how nurses came to know the patient and finding the connection through families was described. Patients who were ventilated and unconscious were unresponsive and often the first impression of the patient was only what was known of the patient and their reason for admission. Nurses sought to find meaning from families whilst caring for patients and the data demonstrated instances of trying to establish a caring relationship:

I mean every situation is an emotional situation in ICU. . . . We get the old grots (patients perceived as debilitated prior to ICU and now long term in ICU) you think . . . you have lesser value for them. But then when we speak to their families and they are really important to their families . . . (N13)

It was important to nurses to relate to the patient in a more meaningful way and protect the relationship with families who not only needed care themselves but were the conduit to the patient. Nurses told how they adapted the way they connected with families to develop or maintain the most effective relationship. Nurses demonstrated sensitivity:

I find if you come around and pull up a chair beside them, that is huge to start off with and I just say 'look how are you going today, what's happening, what are you worrying about, what is the problem' and I find if you start with that straight off you're streets ahead, streets ahead. (N12)

Nurses spoke about setting the scene for optimum care. Nurses described wanting to create calm, wanting the care of the patient to be controlled so as not to add further stress to the patient or their family. The following exemplar demonstrates that establishing a caring relationship with the family creates the setting for best care. In turn, the nurse feels satisfied with the care given:

That means for me that I have looked after the family, they know everything that is going on, they have had tea, they've had coffee, they have seats, they've had the priest. The patient looks pristine in the bed, they have got their hair done, they have got clean clothes, teeth brushed, everything, the place is tidy and they (the relatives) can come in and just be with the patient. They don't have to worry that she looks . . . calm and tidy and clean and is dressed, well that takes away the

stress from the family and I think that is a huge thing. So that is big for me so my satisfaction is all of those things coming together. (N12)

Again, the following exemplar highlights the importance of establishing a good relationship with the family and the resulting benefits to nurse, even in the setting of a premature death. It depicts a situation where the nurse practised what they had determined was best care of the patient and achieved it:

My colleague, an ICU nurse was looking after a patient who was dying, and there was a constant stream of visitors coming in to see the patient to say goodbye. The nurse was able to pick up cues from the patient's wife that she was feeling overwhelmed with the patient's visitors all coming to see her husband. She mentioned to the nurse quietly that she would never be able to lay next to him in bed and this was a moment that the couple valued in their quiet times together. The ICU nurse then reduced the stream of visitors in negotiation with the wife, and was able to move the patient over in the bed so that the wife could lay next to her husband and cuddle up to him. She had the lights dimmed and without the many visitors coming in, the couple could share this moment for the last time. The wife was very grateful, and to me this defines the ICU nurses role in that with all the specialised knowledge, training and specialised technology, the ICU nurse is able to care for the patient. (N10)

Developing trust with the family was essential to managing patient care, particularly when decisions of care involved withdrawing life support. Having established trust with families, nurses described their role in assisting families understand the prognosis and consequent medical decisions that had to be made for their critically-ill relative. The following exemplar is a first-hand account of a situation where nursing care was directed at the family. The nurse described how a caring, trusting relationship was established that helped the husband accept his wife's inevitable death. The nurse also relates how the experience was personally rewarding:

I had this lady who was dying and she was brain dead . . . and her husband hadn't come to terms with it, she was about 85. . . . The family were all very upset as they had come to terms with it and two of the daughters were nurses and so obviously they were talking to the dad. . . . I just felt it was a good day because we started off at the beginning and I talked to the husband and we sort of, well I sort of counselled him through the whole thing with the daughters' back up and it was very peaceful. He came to terms with her being brain dead quite quickly. . . . So we went and had a family meeting and the doctor was wonderful, he was very clear, he said there was no way she was going to recover and all that so it was all very clear. When we came back he sat with her for a little bit longer and then we did the primary extubation (removing the ventilator) and then she took a little while to die and then I said that she is dead now and he said 'OK'. It was all very calm and very peaceful and of course they were sad and everything. I felt that was really, their wishes were achieved. I felt calm and peaceful with the whole thing and I felt the doctors had done a good job. (N12)

Developing a relationship with the family was part of caring for the patient and nurses worked with the family to determine how to care most effectively. Sometimes the care was more about the experience of the family because the patient was no longer the focus of care. Particularly with dying patients, nurses focused on what the family could understand and how the patient's death would be remembered by them. The nurses interviewed for this study had a lot of experience working with families and they had an expectation of how families would respond to their care.

3.4.1.2 Feeling valued by families

Setting goals and achieving them assisted in providing best care to patients and families and nurses looked for feedback that validated their care. One nurse commented that *'I rate having a good day by not even making my patient better but by putting a smile on a relative's face'* (N3). By seeing the relatives respond in a positive way, such as a smile, nurses received validation. In this study, nurses commented on the reactions from families to their care and stated that they liked receiving positive feedback from families: *'And the families, families give you feedback and thank you, you're doing such a good job, just positive feedback'* (N2).

Nurses aimed to give care that made a positive impact on families, particularly when patients were dying. By feeling that they had achieved a positive impact, especially during a crisis or sad situations, nurses received validation of themselves as a nurse which was good for their emotional wellbeing. In this way, nurses engaged in productive activities that managed the patient expertly and helped ease the suffering of the relatives. Nurses recognised the suffering of the family, provided comfort, but did not become enmeshed within it. They knew they had succeeded because they received validation of their care: *'They sent me a card afterwards . . . that little recognition for something that I consider to be normal behaviour towards a family, but if I can make a family feel like that then it helps me'* (N3).

Nurses continually monitored families for the impact their care was having. Restoring calm or allaying fears was tangible evidence that their care was effective. Nurses felt good when the care they gave was validated. In the following exemplar, the nurse restored confidence to the family and this was validated by the family's reactions:

A patient had been extremely unwell but had also got to the point where, lines were coming out and starting to make plans to move forward. But interestingly it was really, really stressful for the family and as they'd been with the patient the whole time they could see . . . all the changes in all of the figures. And suddenly things were looking a little bit different and they were starting to feel a little bit anxious about withdrawing that support and moving on to the next stage.

Especially as this patient's lifespan was really extremely limited as well. . . . Being able to connect with the family at that stage. . . . We had a really good discussion and I think they were really pleased that I'd actually mentioned their anxiety and what it's likely to feel like. I think that was a sense of relief. (N9)

Nurses also sought reassurance that the care they gave was appreciated. Nurses in this study recognised that families sought understanding and reassurance that nurses cared and could see the person in the bed. Receiving expressions of thanks provided evidence to the nurse that they were doing a good job and gave them justification to feel satisfied:

There was a young guy who had come in after a bus accident, severe head trauma and his mum and dad had come in, emotionally really upset and worried about him. At the end of the 12 hour (shift) we had talked that much that I got the feeling that they thought I really understood what was going on with him and they were so thankful that you know I got hugs at the end and shaking hands, they expressed lots of thanks for my care and that made me feel good. I like that. (N14)

Clearly, nurses sought recognition which provided motivation to continue trying and working hard at their job. Overall, nurses in this study described the strongest emotions of happiness arising from caring for critically-ill patients and families when they received validation that they had done a good job. Nurses described some situations with a type of reverence, when they reflected they became emotional and described themselves as acting in almost an angelic way. The experience that the nurse constructs for themselves was overwhelming and provided strong positive feedback and validation of being a good nurse:

I look at, like within this family, I look at what I'm providing for them by looking after their son/daughter is something that I could. I could talk to them the way they needed to be talked to, I could give them the information they needed to hear and I could just provide them time to be with, provide the time the whole family could be there. Those sorts of things, it's no longer not only about caring for the patient, it's about caring for the family and I think that probably, it makes it all worthwhile, even in those situations when you're going to lose somebody and you know it, being able to care for the family so that they walk away from the experience, yes I mean mourning and devastated for the loss of their loved one, but at least walking away going 'That person was, that nurse was a positive in all of that and they did that for me' and I think that is probably a big part of it, I mean that family that rang me and told me when his funeral was on and they sent me a card afterwards, that little recognition for something that I consider to be normal behaviour towards a family, but if I can make a family feel like that then it helps me. I can walk out, have a cup of tea, have a cry, wipe my face and go back in. (N3)

Nurses also reinforce the notion of exceptional care with the family, to ensure positive feedback. This makes them comfortable with the care they gave. In the following exemplar, even though the nurse knew that the patient had received the best possible care given the

circumstances, receiving a card that validated this was the end result which had a positive impact on wellbeing:

. . . So it was all sort of came together and I said to the family afterwards that I have seen a lot of deaths and a lot of sadness and that was very peaceful and you should go home and remember that that was really peaceful compared to a lot of things we see, and they were really happy with that. And then there was a thank-you card to all of the staff and I thought that was really good, I felt good about that. (N12)

Nurses interviewed in this study demonstrated that they sought and received validation of delivering best care within the ICU and that this had a positive effect on their emotional wellbeing. Nurses described happy feelings delivering care at this level, even in the event of the patient dying, nurses sought to feel satisfied with the care they gave. They cared for the family and patient and receiving positive feedback made them feel good about the job they were doing and themselves. Nurses used the validation to affirm their achievement of being good at their job.

3.4.2 Autonomy within the ICU environment

In this study, the nurses interviewed were all experienced ICU nurses and worked at an advanced practice level. They worked with a degree of autonomy, making patient care decisions that were within their scope of practice. Nurses described autonomy in nursing practice that was facilitated by a teamwork model that included high staff numbers and one to one nursing care. In addition, the constant availability of medical staff, allied health and patient care assistants contributed to the ability of nurses to respond and manage patient needs efficiently. The nurses described the ICU environment as supportive of advanced nursing practice and being able to respond to the patient needs autonomously was beneficial to the patient and the nurse:

I think apart from all the usual jobs your washing and your meds . . . feeling like I am achieving . . . feeling like you are getting somewhere, so if you are able to wean (from mechanical ventilation) someone a little bit or if you have been successful putting people on Swedish nose (air filter for tracheostomy or endotracheal tube). I came in the other day and one of my patients was in acute pulmonary oedema . . . she was really drowning and so when we came on and the doctors started their morning round, I said to them 'hey, how about some lasix (diuretic) and how about some Bi-pap' (positive airway pressure via face mask) and. . . that is satisfying when you get to a point in your work, when . . . you are not relying on doctors orders, you can pre-empt that, I like that. But you could see that she (the patient) really turned around that day, she made a dramatic improvement . . . that is an enjoyment . . . satisfying . . . that day in ICU I have done absolutely everything I can for them, there is nothing that I haven't got

around to from a time management point of view . . . you know that every system has been cared for. (N4)

For the nurses in this study, autonomy was explained as having a meaningful input into therapeutic decisions. Nurses acted on their assessment of the patient's needs and commenced new treatment with confidence in their own ability and within their scope of practice as an ICU nurse. Furthermore, nurses expected that their patient assessment and prescription of therapy was accepted by medical staff and supported:

. . . It means well using your brain and bring things to a conclusion which would be seen. For example, if the patient was septic you would give them fluids and then you would go to the doctor and say well I think we need some inotropes (vaso-active drugs) and then you would expect the doctor to say yes he does need some inotropes. (N12)

Furthermore, the high staff to patient ratio and the supportive multidisciplinary environment allowed the nurse to develop skills and knowledge. Autonomous practice came through skill development, support of colleagues and opportunities to monitor treatment effects and changes. The nurses interviewed for this study recognised the opportunity to develop and use skills which enhanced their nursing practice. The nurse in the following exemplar explains that with increased knowledge and autonomy, nurses received respect from colleagues. Nursing autonomously in a teamwork environment was very positive for nurses:

Before I worked in ICU I probably would not have known to even listen to someone's chest or look at someone's blood results, whereas now I feel well I feel like I am . . . I feel more of a nurse in a way. . . . In ICU I can say 'why aren't they on this of why don't we do this or can we start this' or 'this and this, can we change this' I feel a bit more autonomous as well, more of an advocate for the patient as well. Whereas on the wards you know everything should be done but you just can't. The doctors are never there, or the staff aren't there to help even. . . . In ICU you definitely can say 'why aren't you doing this' or 'can we do this, I have changed this.' I feel like you can do a bit more, you can initiate a bit more and it will get done. And I find that it (my initiative) will get respected as well. (N8)

Nurses talked about their own competence and professional confidence in the ICU environment and gave examples of how they took control of what they perceived to be 'nursing' domains. Nursing practice and expertise was difficult to confine to tasks of assessment and response and it was evident in the data that nursing practice was difficult to define. The following exemplar describes an episode of nursing practice that was autonomous. It encompassed complex physical, technical and spiritual care of a patient during a stillbirth delivery. The nurse was very focused on the patient's needs and

experienced satisfaction in providing best care: The nurse had both ICU and midwifery qualifications, and was competent to take control of the delivery:

I delivered a baby here, 26-weeker, still. It was an inter-uterine death about five or six weeks ago and she was from (place in the country), very (nationality), very cultural and nobody expected her to deliver. They thought they would take her up in a couple of weeks and remove retained products of conception because she was critically ill. But they had extubated her overnight and she was awake and I told her that the baby may come. People told me I was cracked, but I felt that sometimes the body does what it does in its own way. So when she had bulging membranes I asked all the doctors to leave us and that we had women's business on our own and everybody left us. We delivered this little baby between the two of us, mum and myself. Then we, I had to ring (maternity hospital) because their midwives had to come over because it was over 20 weeks and they had to register it and take the remains (long pause) but we delivered the baby and it was all in the (pause) encapsulated and so I put it in the basin and told her that it was all complete and that I would open the sac and get the baby all wrapped up and bring him back in, the baby into her. So I took it out and I opened the thing and we washed the little baby, wrapped him all up and brought him into mum and I sat on the bed with mum and the two of us sat there and cried. . . . And we were crying when the other two midwives came. Now the other two midwives came and they did not react at all, they sat there and they went and sat down with us and well we were all crying and then they were talking to us. I was saying to them how lucky we were that the baby came on its own because now mum can grieve and she has seen it. It would be a lot worse if she been in an anaesthetic and she couldn't see it at all, now she can go through the grieving process. So the baby, we left her with the baby, she, we took all the clothes off it so that she could check it out and see that it was complete and everything. Then I got the social worker up and then I got the phone and got her on the phone with her mum in (place) and then I gave her a complete wash and did her hair and everything. The nurses were doing their little bit outside with baby while we did all that and then we gave her the baby back again and then later on when she was going to the ward she actually caught my hand and kissed it. (N6)

Working autonomously in highly emotional situations provided the nurse more control of the situation; the nurse could direct care and experience fulfilment and satisfaction. Overall nurses portrayed themselves as happy and as being devoted to their job. Nurses stated specifically that they enjoyed caring for the unconscious patient and their families. Nurses identified autonomous practice as one of the reasons they loved their job:

I love it, . . . I absolutely love my job. I can see myself still there, I wouldn't mind trying some different things maybe, but no I like it. I like caring for unconscious patients, I like the family thing, I like the whole autonomy thing. (N12)

The ICU nurses interviewed identified experiences of autonomous nursing practice as being important to their emotional wellbeing. Nurses described an environment that encouraged and supported nurses to develop a wider scope of nursing practice. Being able to develop advanced nursing practice skills was described as enjoyable and personally satisfying.

Furthermore, nurses working autonomously enabled nurses to fulfil their role and be satisfied with the care they gave.

3.4.2.1 Achieving goals

Nurses liked to work autonomously in a supportive environment with the ability to set and achieve goals. Achieving outcomes enabled role fulfilment as a nurse which had a positive impact on wellbeing. Achievement was considered in many aspects of their work, including supporting and mentoring other staff. Nurses described a good day in ICU as one where they had achieved something, a goal for the patient, their families or a goal for the unit. Achievement came from working in a teamwork environment:

Achievement in the unit as whole, not just on a day to day basis but just being able to get up and go to work, do a good job know that I'm doing a good job, helping other people to see that in themselves, or helping other people that are not feeling so confident in themselves to feel better about themselves, encouraging them to go out there and do more and learn more and feel better about the job that they are doing rather than, always wishing they were doing something different. (N3)

Nurses expressed satisfaction and drew direct links between their performances at work to how good they felt. Nurses derived feelings of achievement from patient care and identified all elements of nursing care as being part of their goals for the day. Specifically, nurses planned to make a measurable contribution to improving the patient's condition and valued experiences of achievement. Nurses knew where and how they could perform at their best and directly linked the outcome of their care to their sense of wellbeing:

I think apart from all the usual jobs your washing and your meds (medications) and that, feeling like I am achieving, perhaps not even consciously set out goals for the patient but feeling like you are getting somewhere, so if you are able to wean someone a little bit or if you have been successful putting people on Swedish nose (filter for patient to self-ventilate through tracheostomy) . . . and when I go home after most days when I know that I have been thorough and my work has been achieved and my goals have been achieved, I can go home and be completely relaxed. (N4)

Being able to feel confident of their nursing care was important to ICU nurses and promoted a sense of wellbeing for the nurse. Nurses described the responsibility they felt in caring for critically-ill patients and needed to reassure themselves that they had achieved the right outcomes for the patient. Nurses looked at all aspects of care and had indicators that they looked for to assess the impact of their care. For example, nurses used clinical indicators to assess the impact of their clinical care:

Well I feel like I have performed well, I have suctioned them out at the right time and I have turned them properly and their gases are good, they start the day a bit

ahead of the eight ball. As opposed to when you come on the shift, it is all positive in the results. I always get the bloods, all the results before I leave in the morning, even if it is eight o'clock. I just like to have a look at the night and make sure that the potassium is not seven when I go, because I would feel responsible if it was seven (normal range 3.5–4.5 mmol/L). Even if I hadn't given any potassium, I'd just like to know the potassium is 4.3 mmol and the oxygen is 108 mmHg. It just makes me feel good. (N5)

When all nursing care went to plan, nurses felt good and experienced satisfaction. This in turn had a positive impact on their emotional wellbeing. Nurses aimed to feel this way and take home only positives from their job.

3.4.3 Teamwork

One of the attributes of the ICU environment that had a positive impact on the emotional wellbeing of nurses was teamwork. Teamwork was described as working closely with colleagues for common goals and having professional support constantly available. Teamwork was evident from the descriptions nurses gave of caring for patients in the ICU and its supportive role was highlighted:

. . . Probably the support of everybody, normally it is not just you involved with someone's care, it's a lot of people. It's not just the doctors, it's the physios, they are fantastic, you can talk to them. . . . You have got the one patient you are still close to everyone looking after (that patient). Normally the person next to you knows what is going on, you can talk to them. I think the support really helps, I know that there is always someone there, someone who can go further. (N8)

The nurses interviewed identified the staff on the unit as working together as a team for the good of patients and each other. The attributes of someone who worked well in the team and maintained the teamwork environment were described. This was important to nurses especially when caring for complex patients or difficult situations such as grieving families. Working closely and collaboratively with colleagues provided nurses with physical and emotional support. Nurses described the characteristics of nurses they knew they could depend on to be supportive and helpful:

People that listen, that sort of look out for each other and . . . anticipate other people's needs as well as their own. . . . People good at their job. . . . listening. . . . to what is going on in another bed areas. . . . You can be doing your work but you can be aware of what is going on somewhere else and you can go help that person if they are having a difficult time or if they are getting behind with something or getting a bit distressed. (N7)

It was apparent from the data that anticipating the needs of colleagues was essential in the ICU. Feeling supported when looking after critically-ill patients was important to the nurses in this study. It was also important to provide reciprocal support to colleagues. Nurses

looked out for each other and were pro-active in their approach to each other. Working in a team environment meant that nurses felt cared for themselves:

What teamwork means for me is looking out for everybody else that is round about me and if I see anybody struggling I will go in, I will ask them . . . if they need assistance. If they say no I will leave it at that but if they say yes I will go in and I will help out. Just sometimes what goes around comes around, if you are pretty slack and someone else is struggling if you help them out when you are in the same situation one day it is normally reciprocated. (N11)

Nurses described teamwork as creating an emotionally supportive environment to work in. Nurses described working within close proximity of each other and were able to gauge how their colleagues were managing a particular patient/family, especially when nurses knew that the patient was very sick or dying. Nurses ascribed the teamwork environment and its success to leadership and having a senior staff that were experienced in ICU. It was important that the management were cognisant that nurses needed to feel supported in difficult situations: ' . . . *Ultimately that culture comes from good leadership but also enough experienced nurses as well acknowledging that these things are difficult.*' (N9)

The team included managers, staff development nurses and support staff who helped with the care of the patient. One nurse further explained the success of teamwork and why the leadership style was responsible for the operational effectiveness within the ICU:

If you look at the management structure it is a triangle, a perfect triangle with your two senior managers at the top and then the operational people, the people that teach, right down to the people that help you do your turns and clean the floor. Everybody talks, there is a lot of communication goes on in there and for once I am working in an environment where the people in the back office have a clue what is going on the floor. They keep a very close eye on things that are happening. They seem to know everything that is happening as it happens. . . . Without communication nothing gets done especially if you are in charge, you are the conduit, you're sort of in the middle of two triangles. You are right at the fulcrum, you've got everybody from the bottom up to the top nursing wise that you're dealing with and then at the opposite end you've got the medical staff coming from the other way. . . . You are slap bang in the middle. . . . Communication there has got to be absolutely spot-on or things don't run smoothly. (N11)

Effective communication with colleagues was considered important to supporting each other. It was acknowledged that there were individual differences with coordinators, nurses expected that they also had to be outspoken with their own needs. Nonetheless, the teamwork environment empowered nurses to seek the help they needed: Nurses expected that they would be backed up by a team approach:

I mean, your colleagues actually do communicate well with one another and if you are having a bad day, I mean if you are in with a dying relative. It does depend on

the coordinator mind you, whether you'll be relieved or whether people will come. But then it is up to you to verbalise and say look 'I need a break from here or I will go off my head' or 'this family are very demanding, I need a (pause) I will have them springing off the entrance if someone doesn't relieve me'. . . . It is up to you to actually verbalise, you actually have to verbalise. (N6)

The teamwork environment was also described as providing an environment that was conducive to learning. Senior nurses saw that it was part of their role to teach and pass on knowledge. Successful teamwork in the ICU was dependent on all nurses contributing equally, performing all tasks within the ICU:

The teamwork depends on who is on, depends on probably their level of experience but there is good teamwork . . . It is not as though I am asking them to do anything that I won't do myself, because I will pull up my sleeves and work on the floor. (N6)

Teamwork was described as a way of monitoring standards and satisfaction was derived from delivering best care. Nurses placed a high value on the standards of care in the intensive care unit. Working in a teamwork setting meant performing all tasks thoroughly so as not to let the team down. Completing work at a level that was comparable and visible to peers maintained a high standard of care within the unit:

Everything we do is important from resuscitation right to cleaning the floor when somebody has gone out (patient discharged). If they (nurses) go to a bed that is not probably set up (prepared for a new admission) and they take a new patient they will soon know about it. (N11)

Nurses described themselves seeking validation from their medical colleagues and have their role recognised as important within the context of all health professionals caring for the patients within the ICU. Validation from colleagues gave nurses reassurance of their value within the unit and they sought to have this recognised by medical colleagues as well:

Then I speak to one of the consultants that's on because that's a way of me dealing with it and getting their affirmation that it was the correct thing as well, so I knew that I was ok in my judgement regardless of the fact I can't write the orders but just that affirmation that everything is alright. (N3)

Nurses demonstrated that they cared for each other and they spoke of wanting to be part of the ICU team. It was important to demonstrate caring and foster development of junior nurses and this combined with the elements of teamwork were promoted within the ICU. Teamwork in the ICU was valued by nurses in this study and participants gave descriptions of the benefits of working in a team environment. Such things as providing support, educational opportunities, monitoring of standards and looking out for each other were valued and promoted by nurses.

3.4.3.1 Nurturing and social support

Informal learning opportunities were enhanced by the open plan, teamwork environment. Nurses recognised the scope for learning when working in close proximity to each other. Assisting each other was part of the daily routine of working in the ICU and, in this way, new skills were learnt in a very 'hands on' way with the guidance of nurses who were more experienced:

. . . I think learning off your peers and their successes, their mistakes, taking it all in. Just being around and being aware of your surroundings and I think particularly people who you know are competent and knowledgeable. I do tend to keep one eye on them, especially as a junior nurse I watched a lot and learnt a lot. (N4)

The nurses from this study spoke about how they mentored junior staff into caring for families. The function of the team was to keep the momentum of a smooth running unit and to be able to pick up the additional tasks that newer, less experienced staff could not manage. Experienced nurses guided junior nurses into the teamwork culture because they had learnt through their own experience that teamwork was beneficial:

Yeah, I usually just call them aside and say 'I think you had better just go out to the waiting room and just check they're OK and don't leave them out there for too long and, you know, just remember, remember'. Just things like that to remind them. You try not to be interfering and you don't want to take away their confidence either so you say 'oh look, he looked really upset maybe you should go out to him'. Because I suppose because I have been working there a while I can juggle a lot of balls at once, whereas if you've only been working there a little while you tend to juggle only maybe two or three balls at one time, it's that fourth ball that has dropped on the ground and then there's shit! (laughs). (N12)

This type of informal learning was also a way of teaching how to manage the emotional stressors of working in the ICU. The nurses interviewed talked about how nurses were ideally nurtured into looking after patients that were described as difficult. Clinical skills were recognised as important for new nurses to focus on, the more stressful aspect of ICU nursing was coping with distressed or grieving relatives:

Just being in the tearoom and talking to girls who had been there for about six months and the things that they were finding stressful were (dying patients) it hasn't changed in that sense. They are still finding those things difficult and stressful. But the focus for them as well is very much on having to learn these clinical skills. And that's where their focus has to lie and necessarily for a long time. (N9)

Teaching clinical skills to junior staff was a fulfilling ICU nursing role and nurses spoke passionately about mentoring other nurses:

Yep, I absolutely love ventilation, ventilation and neuro (neurology patients) are probably my two biggest passions and I love teaching people about ventilation. I

love teaching people about positioning and there have been a couple of occasions where I have had a junior nurse across from me and we have both had somebody who was really, really difficult to ventilate. Doing an eight-hour shift with that person and showing them the difference it can make with positioning and different modes of ventilation improve a person's oxygenation over an eight-hour period, and the patient you might find is ventilator dependent, that does it for me, that is my best day, that is my absolute best. (N11)

Working in close proximity with colleagues also gave opportunity to chat to each other. This was explained as being a fun part of the work environment and something nurses enjoyed. Nurses valued the opportunity to be able to work and be social with their colleagues:

. . . People who are willing to help you, teamwork. . . . generally most people are friendly and chat and if they're not busy they'll help you and you'll help them and I like the fact that you can have fun as well as work hard and help each other. (N2)

Being able to develop work friendships provided opportunities for fun at work. Nurses described the social aspect of their job as something that evolved over time: *'I've always enjoyed the environment and I am probably really enjoying it more now that, like I have become more social with my work colleagues than what I was five, seven years ago.'* (N4)

The ICU environment described in this study promoted teamwork and had a social benefit for nurses as well:

I just find that everybody knits together. Everybody tries to help each other, well 95% of the people that work there try and help each other and it's a good place for after work sort of get together, there is a social committee where we can do stuff outside of work and there is a few of the nurses there who I actually interact with outside work as well. It has been good for me coming from the (place). I have only been here three years and I have made lots and lots of friends and I think if the situation was the other way, if I had been going back to (place). (N11)

Having social contacts with colleagues both at work and away, helped develop a cohesive team. It strengthened the team and contributed to the emotional wellbeing of the nurse. Teamwork provided the environment that facilitated best practice by monitoring standards of care and supporting autonomous nursing practice.

3.4.4 Previous nursing and life experience

The nursing and life experience contributed to the ability of the nurse to deliver best care and experience feelings of personal satisfaction and happiness from delivering best care. Intensive care nurses stated that their nursing experience helped them maintain control of situations to ensure best care. Experienced nurses were more confident managing patients in ICU. Giving best care helped nurses feel good and maintained their emotional wellbeing:

. . . I think that is something that comes with the knowledge and experience of being in that scenario and having multiple overdoses and personality disorders, you know patients multiple times (laughs). Experience definitely has a lot to do with it and I think to seeing how other people handle it, some people kind of pussy foot around them a bit and say oh 'don't pull at that line, don't do that', other people will say 'sit down and shut up (laughs) or there is going to be consequences!' Seeing how other people do it as well, I haven't just got seven years of experience myself; I've got seven years of observing other people which definitely contributes. (N4)

Nurses also referred to their life experience as helpful in managing the emotional stress of ICU. Nurses described using both their professional and life experience to manage the emotional needs of patients and family. Nurses felt empathetic towards patients and families and tried to keep things in perspective:

I think a lot of it is years of experience really. Like work experience, life experience, probably having gone through a traumatic family situation with my (relative) as well, makes you maybe a bit more aware of (long pause). I think once I had children, it makes you a lot more aware of life and what you have to deal with. Yeah! And I think as well, 27 years dealing with people from different walks of life (long pause). (N7)

Experience was used to develop standards of care that facilitated safe practice and best care:

I think about the kids that come in and they are so new and they have no idea, purge the adrenaline (IV infusion with rapid cardiovascular effect) and things, I think they just need a few more years before you start doing that, I think that I am very careful. (N5)

Nurse identified experience and education as giving them confidence and knowledge on how to manage clinical situations. Working at a higher level of competence with high acuity patients was rewarding and provided nurses with the ability to work autonomously which, as previously identified, was a valued component of ICU nursing:

Also I have done the critical care course so I know what I am talking about and I present myself to others I suppose, in an informed sort of manner, so I am saying to them, I have seen this before, this is what we need to do, I suppose it is experience as well added in. And I like the fact that we look after our patients, we can adjust drugs, we can change ventilation, things like that, that are minute things but can make all the difference, so that is what I mean by autonomy. (N12)

Nurses demonstrated that they were primarily there to care for the patient and their families, to give the best care and being able to react appropriately was essential to their role. They used their experience to determine their approach to emotionally distressed patients/families without becoming emotionally distressed themselves:

The intimacy of what we do to patients and you know how involved you can potentially get with them at such a trying time . . . with experience, I think you can be involved quite deeply with the family in terms of support you can give. It can be as simple as putting your arm around someone and if need be, you might do something like that . . . I think the little things make a big difference, even just letting them talk and vent. (N10)

In the following exemplar, the nurse is describing in detail how the relationship with the family of a critically-ill patient is set up to facilitate best care for the patient and family. The nurse explained that providing this level of care was made possible through experience:

Yeah, well I just find as I watch people in ICU, as I watch younger nurses talk to relatives, you can really see it, they stand far away from them and they stand at the other side of the bed. I find if you come around and pull up a chair beside them that that is huge to start off with. I just say 'look how are you going today, what's happening, what are you worrying about, what is the problem?' I find if you start with that straight off you're streets ahead, streets ahead. And I think if you stick to the rules of two by the bed (two visitors at a time) . . . that is the first thing so I just find if you sit down and explain to them what is going on and use simple terminology. . . . I remember talking to another family and the wife had collapsed and had a massive grade five sub-arach (bleeding into the sub-arachnoid space), irretrievable and the mother was having trouble coming to terms with doing a primary extubation (removing the ventilator to allow the patient to die). There is all this information but they do say you only take in a small amount of what someone is telling you, in that situation, but she just couldn't understand why we wanted to extubated. In the end I said to her because her brain is not going to function anymore, she is not going to be the person she was before this. And I think it was just . . . I just said it to her quickly and then she got it then and she said 'oh well I don't want her to be like that'. So I think it is the way you talk to people, it's the body language definitely, that is a huge thing as well. (N12)

Nurses also described highly developed intuitive skills within the ICU to determine whether some families needed additional assistance. Nurses had developed through experience ways of then managing families who were struggling:

I just go and I just talk if there is something bothering me and I don't detach, like people say they can switch off from stuff. I can't, I can walk into the unit and walk around and I can pick up stuff from families and body language and family this and family that, I can read an awful lot, and I can see things and prevent a lot from happening before they happen. I don't know whether that comes with experience but I am more comfortable with it than I have ever been. (N6)

Whilst experience was identified as providing sound foundations for ICU work, nurses also acknowledged that they needed to continue education and updating themselves with changing technology. For some nurses who were perceived to be very experienced, part-time work limited education opportunities that then became an additional source of concern. Some experienced nurses suffered anxiety because they had difficulty maintaining their education:

Oh look, when in doubt shout, that is my biggest motto, but sometimes . . . when I work two days a week, there are so many things that I am supposed to be a (an experienced nurse) and know all of these things. But I don't, that is when I really stress out. Well at one stage we had four different kidney machines, three different ventilators, all that sort of crap and then I don't get the education half the time and also I don't really sit down at home and do much reading about things. In terms of knowledge balance I'm supposed to be the one that people come to and I just sometimes I think, I am bluffing here. I talked to a couple of other people on night duty and they are doing exactly the same. . . . All of the aging people are finding it a bit stressful because of the skill levels and also you know two days a week for education is sometimes really quite tough. (N13)

This nurse went on to explain that being experienced and having worked there for a long time may have meant that colleagues assumed they were managing to keep up with education. Nurses in this study who were part-time and working eight hour shifts indicated that they felt there were limited opportunities to keep up with education. It was apparent from these descriptions that it was difficult for senior nurses to own up to knowledge deficits. The focus for support was really on the junior nurses and senior nurses wanted to be seen as mentoring them, not needing help:

I think they (junior nurses) cope remarkably well. I remember when I first came to ICU, my stress levels were all over the show, but I think they do have a bit more back up, people are aware; people do come and help them with teaching stuff. (N13)

Furthermore, junior nurses were protected from having to manage the more difficult families with coordinators choosing nurses with experience to manage the difficult patients. Getting the patient allocation so that nurses were given opportunity to learn was important, but when there was a potential for families to be difficult to manage, senior nurses were preferred:

It can be quite difficult if you've got a family like that, they'll tend to put somebody there who can deal with conflict. They tend to put one of the more senior nurses in there and maybe one of the nurses that is a bit diplomatic, they tend to keep juniors out of there, because they don't have the life experience to deal with situations like that. (N11)

However at times, experienced nurses felt that their expertise was abused and that they were given the most difficult patients too often:

When . . . you're looking after awake, agitated, aggressive, non-ventilated patients day after day after day, we were never employed to work in HDU (High Dependency Unit) and I suppose that becomes frustrating because not all of them are nice. . . . Five days in a row is perhaps a bit much. (N3)

Experience was one of the main determinants of how well a nurse could manage in the ICU and helped them develop a working and coping style conducive to working with critically-ill patients and their families.

3.5 Summary

Within the context of emotional wellbeing, nurses were able to deliver best nursing care to patients and families. Best nursing care was caring for the physical, emotional and spiritual needs of the patient and their families. Best care was determined by the nurse and included caring relationships with the patient's family. Nurses liked to work autonomously, within their scope of practice, and they were supported by teamwork and experience. The context of emotional wellbeing within the ICU meant that nurses were experiencing happiness and personal satisfaction from their work and this motivated them to want to continue working in ICU.

The next chapter describes *The Basic Psychological Problem* identified from the data that experienced ICU nurses overcome to maintain their wellbeing. This is explained along with the conditions that contributed to *The Basic Psychological Problem*.

CHAPTER 4. THE BASIC PSYCHOLOGICAL PROBLEM: INABILITY TO PROTECT SELF FROM DISTRESS

4.1 Introduction

Grounded Theory describes a basic psychological process used to overcome a common psychological problem. The problem, identified through data analysis, is experienced by a group who share a phenomenon being investigated (Hutchinson, 1986). In this study, the phenomenon under investigation was the wellbeing of nurses working in the ICU. The basic assumption, therefore, in formulating this study was that the nurses interviewed all shared a common threat to their emotional wellbeing from working in the ICU. Within a Grounded Theory study, the *basic psychological* problem may not necessarily have been identified or articulated by the participants. However, once revealed through the coding process it should be recognisable to the participants (Strauss & Corbin, 1998). In this study, the core problem identified through analysis was *Inability to Protect Self from Distress* which is described in this chapter. Following this, the contexts or conditions in which the core problem occurs are discussed.

The previous chapter described the context of emotional wellbeing. This included descriptions of nursing in the ICU where nurses were delivering best care to patients and their families, in a teamwork environment that supported autonomous practice. Nurses described nursing in the ICU as satisfying when they knew they had given best care and nursing care was validated. From these experiences, nurses described positive emotions that were good for their emotional wellbeing.

This chapter discusses the converse of these experiences, where nurses described experiences where they were not able to give best care, were not autonomous, were not supported by a teamwork environment or their care was not validated. The nurses' experiences of *distress* referred to feelings of sadness, suffering, unhappiness, anguish, anxiety, fear, grief, frustration, disappointment and dissatisfaction.

The conditions causing and influencing the inability of nurses to protect themselves from distress were identified from the data and are described in this chapter. Nurses identified the conditions as: failing to give best care; difficulty caring for the patient or patient's family; loss of autonomy and failure to achieve goals including situations of medical futility; lack of teamwork and/or social isolation in the work environment; and previous nursing and life inexperience or negative experiences.

4.2 Inability to Protect Self from Distress

Mostly, nurses in this study were able to maintain their emotional wellbeing. However, there were incidents in the data where nurses experienced feelings of emotional distress such as sadness, unhappiness, anguish, anxiety, fear, grief, frustration, disappointment and dissatisfaction. Usually, nurses experienced distress when the conditions that supported their emotional wellbeing were different. For example, nurses described experiencing emotional distress when they could not establish caring relationships with patients or their family, were not autonomous, felt unsupported by teamwork or previous experiences in similar situations had caused them distress. Nurses experienced distress in these circumstances because their ability to provide best care was hampered leading to feelings of dissatisfaction and unhappiness. Nurses were unable to protect themselves from feeling frustration, sadness, grief and anger because achieving best care usually protected them from these emotions in ICU. The following exemplar has been broken down to describe an incident of nurse distress.

The participant described a long-term patient in ICU who, over the course of several weeks, experienced several complications and periods of deterioration, followed by small improvements. The nurse describing this incident believed the patient was dying and became frustrated with the inconsistent treatment decisions being made:

She was young, and she originally had (a type of cancer) which was in remission and that was all OK. And then she got a liver problem. . . . But when they resected she ended up having huge problems and her portal vein became blocked. She was chronically ill. . . . She was in renal failure, she had DIC (Disseminated Intravascular Coagulopathy) she was very sick, back and forth to theatre. She did actually leave ICU and made it to the wards and was well enough to go home. She went home one day for five hours which was fantastic for her and her family, but . . . the following day she had a massive bleed again. She started bleeding out of all of her drains. She got taken back to theatre and again she had massive transfusions and massive amounts of problems and she was on massive amounts of inotropes (drugs to help blood pressure). In her whole stay she would have had hundreds and hundreds of blood products. (N15)

The patient's illness trajectory was complex and posed dilemmas for medical management. As described next however, nurses became frustrated at medical decisions they felt were inconsistent and made without consultation with family or nursing staff. The nurse was unable to advocate for the patient or the family and felt powerless. Nurses experienced deep conflict between medical directives and their own assessment of what was best for the ICU patient and family. The nurses described feelings of frustration:

I think the frustrating bit for that was that one day the family kept saying they didn't want to pull out and that was OK. A consultant came on and finally he said,

'we can't do any more. We will cap the treatment (not increase ventilation or supportive drugs), she is not for resuscitation now so if anything was to happen overnight she wouldn't be for resuscitation'. Then the following morning it changed consultants and so the inotropes (vaso-active drugs) had slightly come down overnight and the next consultant decided that because she made improvements overnight that she would be for active treatment and active resuscitation again. So I think even for the family, in that situation, because it is chopped and changed all the time (long pause) . . . (N15)

There were feelings of distress because the medical orders changed frequently and the nurse had difficulty establishing what they believed was appropriate care of the patient. The nurses also had difficulty caring for the family because of the changing situation. The length of time the patient was in the unit meant that nurses cared for them frequently, reinforcing the feelings of being unable to deliver what the nurse believed would have been best for the patient and family. The data demonstrated that long-term patients could be particularly difficult to manage emotionally for nurses. Nurses experienced their own sadness and watched the patient and family suffer for prolonged periods:

I was involved a lot just because she was there a lot of the time, so everyone knew the family, and everyone would say hi to them when you walked passed. And they sat there all day; they were there every single day. I think that was probably the most frustrating thing that when they (medical staff) made her not for resuscitation, everybody was so relieved. All the nursing staff were so relieved that hopefully then she could be let go peacefully. But when the decision was reversed. . . . She still survived for another, probably 3 or 4 weeks, she ended up dying in the unit but it was just, was a huge drawn out, emotional. . . . I think people didn't want to look after her anymore, it was depressing being in the room. As far as the body, the patient goes, she was so swollen and oedematous and with huge amounts of ascites (fluid in the abdomen). She looked embalmed, she looked dead and embalmed in the bed. She just wasn't there anymore, her eyes weren't, you know . . . (N15)

The nurse in this exemplar explains that the nurses were suffering along with the patient and the family. The nurse's own personal resources to manage the emotional impact of the patient were challenged. Caring for this patient became very confronting as the prolonged complex illness had caused considerable changes to the patient's appearance. From the descriptions given, the patient's appearance compounded the sense of failure for nurses. They had tangible evidence that care was failing. Best care for this patient either would have made her better or have been able to facilitate a peaceful death:

So I think for the nursing staff she was just really hard work to look after. The family were lovely which helped . . . I don't know and I always think that it is different for medical staff cause they often don't even go into the room, she was in a side room (pause). When you are not the one spending the whole time at the bedside, they (medical staff) see things differently. They don't probably get the same perspective. . . . Being at the bedside, I think being at the bedside you just

see everything, and you see (long pause). It is more in your face obviously, and maybe you can remove yourself further from it when you are not at the bedside all the time. Whereas when you are at the bedside all the time it is consistently, it is a consistent reminder and you feel like you're doing things for the wrong reasons. (N15)

Being unable to deliver best care was experienced as negative emotional responses in varying degrees. As demonstrated in the previous exemplar, nurses anguished over situations where they were unable to deliver best care, particularly when they could not influence the patient treatment goals. It was demonstrated in the data that this was harmful to emotional wellbeing.

4.3 Conditions: Negative Impact on Emotional Wellbeing

Understanding the relationship between nurses' distress and the conditions within which it occurred is an important step in Grounded Theory. The analysis process examines the conditions that contributed to the core problem (Strauss & Corbin, 1998, p128). The conditions that contributed to nurses' experiences of *Inability to Protect Self from Distress* were identified as: failure to deliver best care to patients and families; loss of autonomy; failure of teamwork and nurse experience. The conditions are outlined below with exemplars that demonstrate the negative emotional responses experienced by nurses.

4.3.1 Failure to deliver best care

Failure to deliver best care was a complex phenomenon with different dimensions that existed between complete failure and success. Failure of best care occurred when the nurse was unable to achieve the care that he/she had determined would meet the needs of either the patient or the family. The perception of success or failure was determined by the nurse caring for the patient and impacted feelings of personal satisfaction. When nurses were unable to do their best, they experienced frustration and dissatisfaction. In the following exemplar, the nurse had become focused on prioritising the care of the patient and dismissive of the families concerns. The nurse described an interaction with family that was experienced as a failure to consider the relatives needs and the negative feelings associated:

In retrospect they (the relatives) were stressed. . . . They wrote a letter complaining about me because I wouldn't change the pillow slip. . . . I said 'I know there is blood, I'll change it'. But they wanted it done straight away and I wanted to get other stuff done first, stuff that needed doing and that did affect me. . . . I felt guilty how ridiculous to not change a pillow slip when they wanted it. I could have explained it a bit better. I probably could have said that I was doing stuff that was more important but I didn't, I just said no. (N5)

In another instance, a nurse described a situation where a decision was made by other ICU staff to transfer a patient from the ICU to a high dependency unit. The nurse interviewed, who was caring for the patient, believed the patient was not well enough to move out of the ICU. The nurse caring for the patient failed to reverse the decision, they could not assert what they believed would have been best for the patient. There was a perception of failure to give best care by the nurse who did not stop the move when they knew the patient was too sick for transport. The patient reacted badly to the move and the nurse described feelings of frustration:

I was with a patient that had been in Intensive Care for a couple of days . . . there was a lot of pressure to move him out of the Unit and on to a high dependency ward. Respiratory wise, (the patient's respiratory status) I wasn't comfortable that he was really ready to go and the decision to move him had been made . . . I felt that I needed a lot more time to really assess him appropriately. There'd obviously been some other communication breakdown between a Coordinator and a CNS (senior nurse) in the High Dependency Unit, which also probably impacted on the situation. . . . I took him up to High Dependency. He was vomiting as soon as we got there. It was horrible . . . it was already 3 o'clock by the time I'd left . . . I had not seen that Coordinator either to really discuss . . . my sense of frustration as to whether that patient was really ready to leave or not. (N9)

Nurses interviewed in this study also experienced a sense of failure from their own inability to keep up to date with nursing knowledge and skills needed to achieve best care. As senior nurses, they felt a responsibility to provide knowledge and support to colleagues. Despite being experienced senior nurses, loss of confidence in their own ability caused discomfort. For nurses who were older and worked part time, the perceived knowledge deficit was experienced as a sense of failure:

In terms of knowledge . . . I'm supposed to be the one that people come to and I just sometimes I think, I am bluffing here . . . I talk to a couple of other people on night duty and all of the aging people are finding it a bit stressful . . . because of the skill levels and also you know two days a week for education (opportunity to attend education provided within the unit for 45 minutes a day during staff change over times) is sometimes really quite tough, you know getting to them for a start and then not having enough education. . . . I just don't feel comfortable within myself really. (N13)

Feeling unable to keep up with skills required to give or assist others with best care was a feeling of failure. Nurses needed confidence in their ability to determine and deliver best care. It alleviated anxiety and stress from the threat of being unable to do the best for the patient and their family.

4.3.1.1 Difficulty caring for patient and/or families

The nurses interviewed identified situations with patients and families that were emotionally challenging and nurses experienced their own distress. These patients were described as: trauma patients and their families; patients or families that reminded nurses of themselves or own family; patients who were aggressive, angry or abusive; and patients who had self-harmed or had preventable injuries; and long-term patients and their families.

4.3.1.2 Trauma/sudden illness: patients and families

Most nurses identified patients who had been admitted following an accident or sudden onset of critical illness, particularly younger patients or those with young families as the most confronting situations to manage in the ICU. All nurses commented that caring for these patients and their families was emotionally difficult within the ICU and caused nurses varying degrees of distress:

Traumatic, unfortunate incidents (long pause) with families I find the most emotional. I mean it is upsetting to see young people and parents pleading with you to do more to keep them alive when you know you can't and (long pause) when tragedy happens and they bring in kids and (or) the mother, might (have) had a sub-arachnoid (brain haemorrhage) and they bring in kids, those kind of emotions are the things I have difficulty with. (N6)

Tragedies were almost always difficult for nurses to manage and there were many examples in the data of situations where nurses experienced sadness. All of the nurses found these types of patients challenging. They had trouble managing their emotions and it impacted on their ability to care. Nurses talked about crying and feeling powerless to help, feeling helpless to respond to patients' needs in an effective way. The emotional responses were evident in the way nurses relayed these instances:

Well we had a little boy, a 15 year old kid who, I mean those emotional things affect me, a 15 year old boy who on the last day of his school holidays dived into the water and broke his neck, and the mother has only one child. Those sorts of things you can just sit there and cry. Or the other boy who killed his girlfriend in a car accident and you just sort of sit there and just watch him with his, honestly just uncontrollable crying where he just, that quiet crying you just (long pause) and usually I would just throw my arms around him but I just couldn't I just had to sit there and just let him go through it and that kind of stuff . . . that is the kind of stuff that I don't feel comfortable with . . . (N13)

In practice, caring for critically-ill patients was often very difficult for nurses personally. Nurses interviewed portrayed their care of the patient as taking care of physical and emotional needs, and that their nursing care extended to the emotional needs of the family/friends of the patient. The following exemplar demonstrates an instance of

emotional distress, personal grief and suffering experienced by a nurse caring for an ICU patient:

(There was) this young kid who was going for organ donation and his poor mum was really quite a-copic (*sic*) with the whole thing, she was just . . . she had consented to organ donation but she was (long pause) the whole scenario around it, when the organ donor coordinator was saying to her 'umm after we err' and she was being as tactful as she could, 'after we retrieve his organs, umm you know you can either see him in recovery or we can send him down to the mortuary' and even at the word 'mortuary' she just jumped up and she was like that really emotional response and I remember really strugg ... (ling) (long pause) really trying to hold it together . . . (N4)

All of the participants had experienced feelings of sadness and grief when caring for patients and their families in these situations. Nurses described themselves as experiencing varying degrees of sadness and anguish.

4.3.1.3 Aggressive, angry and abusive patients/families

Although less common, nurses encountered some patients and/or relatives who were difficult to care for because they were aggressive, angry or abusive. These situations were very confronting and caused nurses to feel unsafe or frightened. It also impacted the nurse's ability to deliver best care for the patient:

I was looking after someone who was just being woken up, who was very aggressive, verbally and he did have the tendency to be physically aggressive as well. You know just trying to do things for him and he was yelling and swearing at you, and I was actually quite frightened. I was quite intimidated by him and I was scared. He yelled when I was right beside him and I felt scared, I felt like my heart stopped and I felt humiliated that you are trying to do the right thing by them and . . . nasty bloke really. . . . By the end of the day I had really had enough and I just couldn't wait to get out of that door . . . (N7)

Verbal abuse was also described as *traumatising*; a feeling of emotional shock and the impact was demonstrated by one nurse who had difficulty returning to work following an incident with an aggressive relative. The participant experienced reactions that were out of character and unexpected:

Once I got very traumatised by a relative here which I reported, a very angry relative and I actually panicked going home in the car and I never came in the next day and I had (name and name, management) ringing me because it was just so unlike me to actually have reacted the way I did. But I took it very bad. He threatened me, he told me that he was a (occupation) and his son was in (ICU). All I was doing was going to the toilet and I wasn't even coordinating. He was out in the corridor and he was pacing up and down, he was hyperventilating and everything. Because he was so bad I stopped him and I asked him could I assist him and he told me that his son was in and he was fecking and blinding and screeching and roaring and everything. (N6)

Other nurses described losing confidence and becoming uncertain when the relationship with families had not been established in a positive way. Nurses described becoming uncertain when families did not trust them. Nurses expressed having difficulty in these situations, a contrast to having their care validated:

If you get somebody (family) quite difficult and they don't really understand and they can be a bit like 'oh why are you doing this and', it kind of makes you . . . question . . . not that I am not doing my job right, but you think 'oh, I wonder why they think that of me' . . . it does definitely. (N8)

Caring for patients and doing the best for them and their family emerged from the data as foundation goal for nurses in the ICU. Experiencing angry or aggressive patients and families interfered with the ability of the nurse to deliver best care and as such caused uncertainty, fear and distress.

4.3.1.4 Self-harm and preventable injuries

Other types of patients that contributed to nurses suffering included those admitted following self-harm or reckless behaviour. Nurses experienced sadness and frustration:

. . . I think it is all the frustrating things like the drug overdoses, that sort of, it's a sadness isn't it. . . . because it is society isn't it, if you look back they were all abused as children, if you look through their notes 99% of them are abused and neglected and stuff, and it only really 1% of them that have a true medical illness, it is very sad, I find it very sad and very frustrating as well, you feel like you just want to go 'oi what are you doing'. . . . I just feel sorry for them 'cause I think you just deal in the now, you can add in the background, it makes you more compassionate but it just makes you annoyed that you can't stop them, it's a waste. (N12)

In some circumstances or conditions, nurses had difficulty establishing a good rapport with families. This resulted in feelings of dissatisfaction that arose from a lack of validation for their care:

Some families are completely closed and (long pause) you can only facilitate so much, you can only give them what you can give them and whether they take it onboard or not is in their makeup, not in the way you've presented it. The families I find it harder to get through to are often the very dysfunctional families. . . . Because often dysfunctional families will come together in a crisis but the most dysfunctional families are hard to get through to (long pause) and you get no thanks and you get no recognition of the job that you've done. (N3)

Nurses struggled under these conditions to find satisfaction and validation for their care. The negative emotional responses were detrimental to emotional wellbeing.

4.3.1.5 Long-term patients

Long-term patients in the ICU often require ventilation via a tracheostomy tube and they are often aware of their surroundings and interact with staff. Nurses described these patients differently, having come to know them and their families as people. Many of the nurses interviewed referred to one particular patient who passed away in the unit after seven months of intensive care, for most of which the patient was conscious. The actions and interactions of all the nurses who cared for this patient were different to their responses to other patients. The relationship with this patient was unique and the effect of his death was talked about differently, with a sense of disbelief that had to be processed:

He was in the unit for seven months or something and was completely awake and with it for probably five out of that seven months and well you're either going to die (long pause) but we all knew it was coming. But when it actually occurred it was just devastating for everybody because that was his room and he was there every day and we knew him so well and the family, the family were always there, every day. But this one, we all knew he'd never survive but he'd bounced back from the ward five times. You don't expect the day that it happens, you expect him to never survive but you don't expect the day that it happens and to feel the way, I mean he was so lovely. So, when you're with somebody that's just been part of the furniture for so long, and particularly an awake and neurologically intact part of the furniture, somebody that will talk to you and tell you stories . . . (N3)

The experiences of caring for very long-term patients or those known to the unit due to multiple admissions were different for nurses. They spoke anticipating death as the outcome and experiencing a level of grief for these patients. The relationships with the patient and family had become established at a more familiar level:

I don't think she'll ever get out of the unit, she's, she was over here on holidays and she's stuck in a strange place. I mean, thank God she's got her family, it's a really sad case, she's completely with it and completely awake. She knows exactly what's going on and I think that's harder to take than somebody who's had (long pause) a head injury and has no idea because to be completely awake, and she's an ex-nurse . . . (N3)

Caring for patients who were awake and intubated (endo-tracheal tube or tracheostomy *in situ*) provoked feelings of anxiety for the nurse. Communication with this type of patient was described as *extremely difficult* and created anxiety for the nurse:

I think, only one of the other things I've been thinking about, the things that actually do make me feel quite stressed and that can often be the patients that are completely conscious in Intensive Care. And, you know, they might be ventilated and obviously communication can be extremely difficult because they need things, it's often difficult to determine what that is. And it also makes you realise that we are very task orientated in what we do because, 'I've still got to do

this, this and this.' But, um, the bit that actually makes me feel quite stressed at times . . . (N9)

The conditions described in this section represent the most commonly identified situations with patients and families where nurses experienced an inability to protect themselves from distress. Caring for patients and their families following trauma or sudden illness, particularly when the patient was young, caused nurses' distress. Patients or families who were aggressive or abusive, patients admitted due to self-harm and long-term patients were all potentially difficult for nurses to care for and led to feelings of distress.

4.3.2 Loss of autonomy

Working autonomously was valued by the ICU nurses interviewed and was used to describe the ability of ICU nurses to prescribe and achieve treatment goals for patients. It was discovered as an important condition that when breached, contributed to the core problem. When autonomy was threatened or removed, nurses experienced an *Inability to Protect Self from Distress*. In this section, loss of autonomy and the impact on the nurse is described.

Threats to autonomous practice were identified as arising when nurses were not supported by their colleagues, in particular medical staff. Nurses strived to give the best nursing care possible and this was assisted by setting patient-centred goals. Nurses in ICU expressed that achieving patient-centred goals made them feel happy and satisfied. When nurses planned patient-centred goals that were not supported by colleagues, they became frustrated and angry. These feelings prevented them from experiencing personal satisfaction and had a negative impact on emotional wellbeing. The most commonly expressed emotion was frustration:

I feel frustrated sometimes when you know what you would like to get done to the patient and the doctors don't so if you differ on potential care paths or some protocol or practices or what is usually done. . . . One of my patients CVP (central venous pressure) was low and all the indicators that they needed fluid were there and I went to one of the doctors and said 'can he have a bit more fluid' and he said 'oh no, I think' I can't remember what his answer was but he thought he had something else and I thought 'no you're wrong, you ARE WRONG' (N4)

Nurses expressed frustration most commonly when they were challenged or not included in important decision making and perceived that the quality of care was compromised. Frustration, defined as 'a feeling of disappointment, exasperation, or weariness caused by goals being thwarted or desires unsatisfied' (Encarta Dictionary: English Online) was stated repeatedly:

. . . If the patient was septic you would give them fluids and then you would go to the doctor and say 'well I think we need some inotropes (vaso-active drugs)' and then you would expect the doctor to say yes he does need some inotropes, and that is probably where the conflict comes. . . . frustrated, very frustrated, I think it's sometimes (long pause) the junior staff or doctors that don't know you, not trusting your opinion. (N12)

Nurses experienced extreme frustration as described in the following exemplar. Nurses were frustrated that the patient care was sub-optimal and that there was a lack of respect for their knowledge. Conflict with junior medical staff created a negative work environment that was unpleasant and caused distress:

. . . Making them, getting them to understand why we wanted what we wanted and why the treatment that they delivered or wanted to deliver was incorrect. Getting them (junior doctors) to understand why we needed the consultant there and I mean that went on for three hours when we finally stamped our feet up and down and went 'No, this is not on.' I got the coordinator involved and said 'We need a consultant in here.' The consultant came in and half an hour later the patient was relatively sorted. I find medical staff who let their egos run their medical practice very frustrating because they need to take a step back and go from their knowledge base, and listen to the nursing staff who do it for years and years and years and look after these patients, so that we can work together not them and us. (N3)

Nurses talked about their own professional credibility and believed that there were some traditional nursing behaviours that hindered nurse autonomy. Nurses experienced frustration that centred on communication difficulties with their medical colleagues. At times, nurses stated that their expertise was overlooked:

Sometimes you find nurses aren't treated with respect and that would possibly be the doctor thinking 'oh you're just a nurse, you don't know what you are talking about.' So that makes me frustrated. (N12)

When they were not listened to, nurses reasoned that it was not necessarily personal. They were questioned because of preconceived ideas about nursing. As explained by a nurse in the following exemplar, these types of conflicts open up a long history of nurses feeling less confident about their profession:

It kind of makes me think, (it) makes me question myself but then I think 'oh, no I am right.' I will justify and that makes you angry as well. . . . I think it's because it's the old doctor/nursing thing . . . (N8)

For some nurses, conflict with the opinions of doctors in what was believed to be best care of the patient, was described as the *biggest* problem they have had to deal with. The nurse acknowledged that the decision to continue treatment was the doctors, but for nurses involved, there was a loss of autonomous care and a subsequent conflict in treatment

decisions. Nurses had difficulty reconciling treatment plans for a patient when they thought the treatment was futile. Nurses described working in these situations as emotionally taxing:

I think the biggest problem I have had since I came there is with medical staff and treatment has been absolutely futile and we have had a team discussion about it and the medical staff just won't let it go. . . . We know that it is a very, very difficult decision for consultants to make and also the continuity . . . where you will have a team of consultants coming in for two days and they will go and do things the way they like things done and then you will have another two coming in for the next two days and do things completely differently. . . . Situations like that are very, very draining on you. (N11)

Descriptions of caring for *futile* patients demonstrated the strength of distress experienced by the nurse. Describing a patient as 'rotting' conveys the hopelessness felt by nurses when they wanted the patient not to suffer. The nurse felt powerless to change the course of suffering for the patient and experienced a sense of futility and distress:

A lot of the time you can actually see them rotting away right in front of you, and you know 99 out of times of 100, that they are not going to leave ICU and if they do leave ICU they are not long for this world. (N11)

In the following exemplar the nurse described administering prescribed patient care therapies as 'torture' and felt despair for the family. The nurse described feeling *terrible* and that the patient was *decaying*, a macabre description that implies a deep conflict in the care the nurse thought appropriate for the patient:

I was looking after a patient who I felt the treatment we were doing on him was futile and discussed it with a senior consultant. I discussed it with a senior registrar and we came to the agreement that we would cap treatment where it was, we wouldn't offer any more treatment, we wouldn't withdraw treatment at that point, but we wouldn't offer any more. I felt pretty happy with that decision, the family were involved as well and then two days later we came back and treatment had escalated when new consultants had come on. The patient, all I can say is that we basically flogged this guy for a week and then he died. . . . I felt terrible, not only for the family who had to go through another week of absolute torture and an alien environment looking at their decaying relative on all this machinery but also for the nurses who emotionally deal with that. (N11)

For nurses working in ICU, a loss of autonomy caused emotional conflict and distress. Nurses in some situations lost confidence in giving best care and questioned the decisions others were making about the patients in their care. Operating with these uncertainties caused emotional distress for nurses and affected their relationships within the multidisciplinary team. For nurses, loss of autonomy made nurses more vulnerable to experience distress. When nurses believed treatment prescribed by others was not in the best interest of the patient, nurses became more sympathetic to the families, and

experienced the families' distress in the process of trying to advocate for the patient. Being able to work autonomously helped nurses feel they had given best care and this was when nurses experienced emotional wellbeing.

4.3.3 Failure of teamwork

The work setting within the ICU has been previously described as a teamwork environment which included working closely with colleagues for common goals and having professional and social support available. Within the context of emotional wellbeing, failure of teamwork led to feelings of anxiety which were unsettling. Part of the 'teamwork' environment perceived by nurses to be important was the unit morale. When the team was perceived as dysfunctional, nurses were unhappy. For the nurse in the following exemplar, the unhappiness led to feelings of not wanting to be at work:

Emotional well-being at work is related to who I'm working with . . . the state of the unit as far as morale. The grumblings that are going on or the bitching and fighting that's going on really unsettles me at work. . . . Don't want to come to work, don't want to talk to anybody, I prefer just to go into my bedspace and draw the curtains or close the door, do my work, don't talk to anybody, leave me alone and I get unsettled. (N3)

Having a consistent work environment including teamwork meant performing their job to its best and as part of this; nurses revealed they had definite expectations of themselves and their colleagues when it came to the team behaviour. When these standards were breached by colleagues nurses described being angry and compromised with their colleagues which was uncomfortable. Nurses felt let down by incidents that went against the teamwork ethic and experienced conflicting emotions that were difficult to deal with:

I don't even make an issue unless I am really pissed off, if something, if I get to a patient and nothing is done and somebody is accountable for it then I feel a bit, I stew . . . if the patient is not washed, or unkempt, or things obviously haven't been done like dressings or, I mean most of the time I know how pushed we can be but I mean, there are times at work when it is completely quiet and that's when things don't get done then that is when I get really a bit miffed . . . I do stew, I don't like confronting somebody about it or if I do I've really got to think about it and I really think, because I don't like confrontations so I have really think about getting people to account for their care . . . (N13)

The data demonstrated the importance of the relationships between the nurses in the unit and the impact when teamwork broke down. When relationships between colleagues were not supportive, nurses suffered anguish and felt upset:

A staff member that really did upset me . . . (this person) just got stuck in to me for whatever reason and it was horrible, it upset me for the rest of that shift. It

upset me every time I had to work with (that person) again, and I carried on as nothing had happened but that did impact on me when I was at work . . . I didn't like it. (N7)

Nurses relied on teamwork to create a working environment that facilitated best care of the patient/family and care of each other. Working with nurses who did not join into teamwork caused nurses to become frustrated and angry. Nurses stated that encountering uncooperative colleagues compounded any other stresses they may have been experiencing, describing the impact as miserable. The following exemplar describes the experience of when one nurse was coordinating the shift and some of the nurses on that shift were not responding to the team ethic:

Well I was coordinating, so it was busy and there were four coming in so I would ask people to do things for me like go to direct hand over and simple things and they would roll their eyes and go 'if I have to' and this sort of attitude and it was coming from people that do it all the time so I should be used to it but it just really annoyed me. It was coming from young people who are only second year nursing and that is really insulting and annoying and it was coming from agency nurses so it was coming from all different people. I got over that, but that can, make your day miserable . . . It just adds to my stress, and I feel like I then need to explain my job, which I shouldn't have to because that is wasting time, like we were busy and I just needed someone to do simple things. I wasn't asking them to move the world, I was asking them to go to direct handover, to wash the patients when they had two and then they wanted, another one wanted to go home early just because she wanted to go home early and just little things. (N2)

Nurses who didn't work towards teamwork created stress for other nurses. Maintaining teamwork within the ICU was described as particularly important to nurses when they were coordinating the unit for the shift. There is often a lot of pressure to move patients in or out of the unit combined with ensuring adequate staffing levels, skill mix and managing staff. In the following exemplar a nurse was describing a situation when they reacted in anger to a dysfunctional team situation and the consequent distress. It demonstrated that nurses depended on a functional team to run the ICU and to avoid their own distress:

I feel shit about shouting at people (laughs) so it is a circular situation if I enter that because I am feeling shit and I shout at people and then I feel doubly shit, so I try not to do it. (N11)

Nurses tried to find their 'place' in the team and it was expected that the workload given to them was appropriate. Feeling incorrectly placed within the team for a shift, that is given a patient that the nurse deemed not sick enough for their skill level, was experienced as disappointment and frustration:

I get really bitchy, as probably most of us do, or it depends there's a few situations I've had happen where (long pause) and I've had to stop myself bitching to the

coordinator, I have a look around me and realise that there's a relatively junior staff member with a sick patient, so I'm put there (allocated to an 'unsick' patient) to support them and I go 'Ok, no problems,', take a bit of a breath, everything's alright. (N3)

The nurses in this study sought support from their colleagues through teamwork. Nurses expected to feel that they were supported, especially when they made mistakes. In the following exemplar, the nurse was offended when an official report was completed over a relatively small error. In this situation, the incident reported was over placing a signature on the wrong section of a newly introduced form. There may have been merit in using new forms, however in a supportive teamwork environment; the nurse who made the error should have been given the option to complete the form him or herself:

The thing that really pissed me off was when nurses dob on you . . . when we had the new heparin chart and the doctors were writing a heparin change, I signed it on that chart without realising the new changes meant that you had to write it on a different part. . . . One of the nurses put in an AIMS (Australian Incident Monitoring Safety form) and I thought . . . I didn't confront her, I didn't kick her up the backside (laughs) I went up to her and I said, look well this is how I was told to do it and I am really sorry (laughs). . . . Those sorts of stupid things, petty things really annoy me at work. . . . If that was me, I would just . . . talk to them. There have been minor changes at work and if it became an environment that was bitches all around, that would really change it for me, I wouldn't want to be in an environment like that. (N13)

The impact of feeling unsupported at times led to frustration and emotional distress for nurses. Working within this context, nurses found it difficult to achieve best care and were more likely to feel unhappy and dissatisfied. Teamwork was perceived as creating a work environment that was positive for ICU nurses. The positive and negative characteristics of teamwork and the ICU work environment, as described by the participants have been summarised in Table 4.1.

Table 4.1 The characteristics of teamwork and the ICU work environment

POSITIVE WORK ENVIRONMENT	NEGATIVE WORK ENVIRONMENT
Teamwork	Failure of teamwork
Support each other Feel supported Respect Common goals Patient care optimal Social	Unsupportive Disrespectful Conflicting goals Patient care sub-optimal Isolating
Facilitates teamwork	Hinders teamwork
Open area Close proximity to colleagues facilitates teamwork Management part of the team	Side rooms Can't see colleagues easily Management who do not work as part of the team
Teamwork atmosphere	Non-teamwork atmosphere
Friendly Collaborative	Not friendly Confrontational

4.3.4 Previous nursing and life inexperience or negative experiences

Within their own personal characteristics, nurses identified experience as one of the conditions that helped them manage their emotional wellbeing. The nurses interviewed were all experienced ICU nurses and one of the conditions identified that promoted emotional wellbeing was experience. Nurses were able to draw on their own personal experience to care for critically-ill patients and achieve their goals.

Nurses relied on their own experience of working in ICU to feel confident and provide best care. One participant with three years ICU experience and the least experienced of those interviewed, described ICU as a constantly changing environment. The nurse relied on experience and having not forgotten how to do things. Nurses relied on their skills and experience to allay their own fear of not being able to provide best care for each patient they encountered:

I notice when I go on holidays and I come back, I feel a bit nervous about going back. . . . I really think about it, do I know my stuff? When I have been away from work for a long period of time . . . it is such an area where it is changing all the

time . . . I wonder what patient I will get . . . I wonder if I will remember to do this or that. I get a bit nervous, it is nervousness . . . (N8)

There were examples of nurse's distress that were attributed to their own personal life experience or situation. Nurses stated that they identified with some patients in a personal way or feared that they may experience a similar fate as the patient or their family. For example:

I reckon the stress I take home the most is when I see people that I can relate to like a might see a girl sitting next to a sister critically ill and I think of my sister or I might see a young boy who has been out driving in cars and I think 'oh my God, what is going to happen in 10 years time when my two are '. . . (N2)

Nurses were not only aware of these reactions in themselves, but they recognised their colleagues as having trouble with certain patients:

I bet you if you asked every nurse in ICU there will be certain cases or certain types of patients that will probably hit home. For instance, the other day a senior nurse broke down because there was a patient in there who had just given birth. A few days previously, and the baby was brought in to be with her, and that was too close to home for her. (N14)

Nurses recognised that they had the capacity to lose control of their emotions which was undesirable. As stated, '*You don't want a senior nurse bursting into tears in the middle of the unit*'. (N14) The distress experienced by nurses was not restricted to feelings of sadness or grief. Having previous negative experiences in ICU can also cause a level of anxiety when anticipating encounters with similar patients. In the following exemplar, the nurse has had experience of caring for dying patients and being unable to give the best care. The nurse has experience of this on more than one occasion and anticipates it will happen again:

In patients who are dying, I don't like seeing them left in rooms on their own. Often they'll have family with them, sometimes they don't. And even those times that they don't, I'd like to be with those patients. It's not always possible, I mean I guess you've got, the resources and budgets and those sorts of things to think about. But I find that probably really difficult, trying to look after conscious patients (doubled with a dying patient) who are completely stable but are demanding and they usually have lots of pain issues and those sorts of things. They need lots of care, and then also real end of life issues. . . . And the other patient gets left and that doesn't feel quite, quite right to me but that's more of a personal sense of what I'd like to do I suppose, but those are things I find quite stressful. (N9)

Having repeated experiences of stressful situations can also increase the frustration and anguish of the nurse. For example, as previously identified, caring for patients who were admitted following a preventable event such as drink driving caused nurses to feel

frustrated. After caring for several of these patients, the sense of frustration and anger increases:

A 20 year old that gets drunk and gets behind the wheel you just want to slap them round the head if you have them because, you've done this damage. But we can't be angry at them and help the family at the same time. So that's an opinion that this guy was an idiot and he should have done something different but they still deserve to be looked after. The same way as any other patient in the unit, I've found suicide attempts (long pause) I'm getting better but . . . But we can't be angry at them and help the family at the same time. . . . I had an opinion this guy . . . should have done something different but they still deserve to be looked after, the same way as any other patient in the unit. (N3)

Experience as a condition referred to a combination of the nurses' own personal experiences and their ICU experiences. At times nurses identified with the patient/family because there were similarities between the nurse's own life and that of the patient and family. In other circumstances, experiences of looking after certain patient types evoked negative emotional responses that nurses had difficulty with managing.

4.4 Summary

The basic social and psychological problem identified in this study was an *Inability to Protect Self from Distress*. Distress was identified as feelings of sadness, unhappiness, anguish, anxiety, fear, grief, frustration, disappointment and dissatisfaction. When nurses suffered, their ability to give best care was reduced. Conditions that contributed to nurse distress were identified as: failure to give best care; difficulty caring for patients and/or families; loss of autonomy, failure of teamwork and the nurse's previous nursing life inexperience or negative experiences (see Figure 4.1).

The next chapter describes The Basic Social and Psychological Process that experienced nurses in ICU use to maintain their emotional wellbeing. This includes a description of the strategies nurses used to overcome the conditions that lead to them to experience distress.



Figure 4.1 Conditions identified that contribute to the nurse's inability to protect self from distress

CHAPTER 5. THE BASIC SOCIAL AND PSYCHOLOGICAL PROCESS: PROTECTING SELF FROM DISTRESS

5.1 Introduction

The overall aim of this study was to explore how experienced ICU nurses maintained their emotional wellbeing. In Chapter 3, the context emotional wellbeing and the conditions facilitating this were described. Chapter 4 outlined the core problem of *Inability to Protect Self from Distress*, experienced by all of these ICU nurses and the conditions that inhibited emotional wellbeing. This chapter describes the Basic Social and Psychological Process of *Protecting Self from Distress*. Intensive care nurses were found to use this process to protect themselves from the core problem and maintain their emotional wellbeing. The process consists of three independent phases: *Delivering best care*, *Validating care episodes*, and *Distancing self from distress*.

5.2 The Process of Protecting Self from Distress

The basic social and psychological process identified in this study was named *Protecting Self from Distress* and will be used to describe the strategies nurses used to overcome adverse conditions that threatened their emotional wellbeing. In Grounded Theory, the substantive theory is deducted from the data and the process described happens in context, 'sequentially, subsequently, simultaneously, serendipitously, and scheduled' (Glaser, 1998). The process described in this study represents strategies used by ICU nurses in response to conditions that varied and were not necessarily all present or all absent at any one time. Nurses used particular strategies to minimise their distress and thus protecting their emotional wellbeing.

Within the basic social and psychological process, *Protecting Self from Distress*, three independent phases were identified: Delivering best care in ICU, Validating care episodes, and Distancing self from distress.

Delivering best care describes nursing in the ICU when conditions facilitated emotional wellbeing by enabling ICU nurses to deliver best care to the patient and family. When this happened, nurses were happy and experienced personal satisfaction which had a positive impact on their emotional wellbeing.

Validating care episodes describes strategies used by ICU nurses to validate the care delivered. Most commonly, nurses described reflecting either on their own or with colleagues about ICU incidents and this helped them to validate their care and find meaning

and perspective. Nurses actively sought support from colleagues and feedback from patients' families to validate their care. There were times when nurses protected themselves from distress by sharing work experiences with their own friends or family. Nurses also placed their distressing emotions in perspective by looking at the big picture and justifying the care they gave.

Distancing self from distress describes strategies that created a physical or psychological barrier between the nurse and experiences at work that were actually or potentially distressing. This included strategies such as using distraction, listening to music on the way home, emotional barriers and self-caring activities. *Distancing self from distress* included selecting patients and, at its extreme, leaving ICU nursing.

Nurses interviewed for this study described using the strategies identified in this chapter to protect themselves from distress. The strategies identified were often used in combination, and the degree to which nurses experienced the need to protect themselves or felt protected was variable and dependent on the conditions experienced. Overall, by protecting themselves from distress, nurses maintained their emotional wellbeing.

5.3 Delivering Best Care

The context of emotional wellbeing in the ICU was described as positive emotional responses including happiness and satisfaction. Nurses experienced these feelings when the delivery of best nursing care to patients and families had been achieved. Best care meant that nurses had done their best within the context of the patient's critical illness. Best nursing care was a condition that was positive for nurse wellbeing. Caring relationships with patients and families, autonomous nursing practice, supportive teamwork environment, and the experience of the nurse facilitated the ability of the nurse to do their best. From the interviews with nurses, it was apparent that nurses worked towards achieving best care for each patient. Being able to achieve best care was positive for their wellbeing. The following exemplar has been broken down into several small excerpts and illustrates emotional wellbeing experienced from achieving best care and how the nurse was protected from distress:

There was a patient who was dying, he and his wife were in hospital at the same time, and they both had injury. The man was dying in intensive care, he was in ICU, and his wife was in an orthopaedic ward. We were able to get the wife down with all her bed traction. We were able to park the wife next to the husband who was dying with tubes in and everything. We were able to give them some privacy, pull round the curtains and she (the wife) was able to hold hands with her husband. (N10)

In this account of nursing in ICU, the nurse described an episode where the specific needs of the patient and his family were addressed by the nurse. The nurse recognised the importance of the patient, who was dying, having his family with him to say goodbye. The nurse assessed the best care of the patient as having his wife with him and planned how this would take place. The nurse described teamwork as a combined effort, one of the conditions that nurses identified as positive for their own wellbeing:

It was a combined effort with the shift coordinator (ICU nurse who coordinates the shift) and other ICU staff helping to bring the wife down and make space. At one point the medical team caring for the wife wanted to see her and I had to explain what was going on. They didn't like me asking them to leave and were being really difficult. In the end one of our ICU consultants told them to leave the wife because she was with her husband who was dying. I felt supported because everyone in ICU was working to facilitate the husband and wife being together. (N10)

This exemplar demonstrates autonomous decision-making, facilitated by teamwork that included the multidisciplinary team. The team was needed to assist bringing the family together. The nurse felt the decision of best care was supported by the teamwork, approach, particularly by the nursing coordinator and ICU consultant who validated the decision making. Achieving this goal involved autonomous decision-making supported by teamwork and it was a positive experience for the nurse: *'That was probably one of the most amazing things I have seen'*. (N10)

The nurse went on to comment further and described the emotional impact for nurses in these instances of patient care. It was clear from the following statement that the nurse had reflected at length on the episode of care and attempted to put in perspective what was achieved during this experience of nursing care:

I felt really honoured that I was able to have an impact in that situation because there's no other real profession where you can do something like that. To have such an impact in someone's life at that critical point is a huge honour that you just can't define. It's just by a small action which with nursing . . . when you look at the emotional side of care and nurse led intervention it's hard to define. . . . The wife was really grateful (who was present when he passed away) and just them those last few hours, the last hour or two with him . . . that was such a critical time in their lives and something that is hard to measure. (N10)

The nurse stated that the episode of care was difficult to measure in terms of quantifying what had occurred for the patient and his wife but it was important. The nurse gave the following description of what had occurred for both the patient and the nurse:

It was one of those sorts of things that really lasts in your career. . . . I felt I was able to help impact (at) that critical point but then I was also able to step back and

let them have their time without obviously interfering too much. . . . It's about their moments and not anybody else's. (N10)

The episode of care in this exemplar required best care nursing care and demonstrated advanced skill practice. It also revealed that the experience of the nurse contributed to their ability to plan and achieve patient-centred goals:

In those situations . . . (it's) having the maturity and experience dealing with critically-ill patients and . . . having a sense of their needs at that time. They don't need somebody in their face every five seconds. You have to really create a very fine balance on how much you get involved and how much you step back and knowing when to as much as you can in your role emotionally and then be able to step back. (N10)

Delivering best care to patients was very satisfying for nurses and something they worked towards achieving. Nurses were able to reflect on these episodes of care and feel good about themselves. Achieving best care was good for nurses' emotional wellbeing and an experience they sought to repeat because it was highly valued:

It's the moments you remember from your career are these sort of moments . . . I was able to have a deep impact even in a small way by letting the husband and wife say good bye to each other. . . . They were spending their last moments together . . . making a patient a bit more comfortable or helping a family in a difficult time. Those sorts of moments are what you define as highlights in your career. (N10)

Whist relaying this episode of care about the dying husband and his wife the nurse spoke about the impact on a student nurse who was also assigned to the patient as supernummary. The nurse spoke about teaching the student one of the most important aspects of ICU nursing:

There was a student nurse with me being preceptored to intensive care. . . . Being able to teach was really rewarding. Obviously we get excited as nurses about pressing buttons and getting into the nitty gritty of intensive care . . . the technology side of it. . . . But then the student being able to see that part of intensive care nursing as one of the most important parts of intensive care was really rewarding. The student was really impressed with the situation even at such a young part of (the student's) career. (N10)

After the patient had passed away, the nurse took time to talk to the student, to teach and nurture the student nurse about ICU nursing. The nurse also experienced some feelings of sadness at the passing of someone from life to death, however this was overcome by the experience of facilitating best care. This was recognised by the nurse as a time to reflect and debrief, particularly in regards to the student nurse who was unfamiliar with ICU:

It was a really amazing moment, it was hard not to get a bit teary at the same time. The debriefing, we talked about it (having the wife with the patient)

afterwards with the student who thought that was an amazing part (of nursing in ICU) something the student will remember forever. (N10)

Working in the right conditions of best care, caring relationships with patients and their families, autonomy, teamwork and using their experience was good for emotional wellbeing. Nurses felt protected when: they were achieving their goals; felt valued; were part of the team; their care was validated; and they were able to debrief and reflect. Nurses used these strategies to maintain their wellbeing or promote the conditions that optimised their emotional wellbeing and when this was achieved, nurses were able to give the best care and feel emotionally well.

5.4 Validating Care Episodes

Most of the nurses interviewed talked about validating care episodes by reflecting either on their own or with colleagues as a way of coming to terms with the many aspects of their work. Validating was a way of nurses confirming to themselves that they had given the best care possible. Nurses acknowledged that ICU could be emotionally challenging, and sharing experiences with their colleagues was a process of validating care and seeking understanding. Nurses also had to come to terms with the grief and distress of families, particularly when a young person died. Nurses described needing to reflect with their colleagues, including the multidisciplinary team, because they shared common experiences and understanding of the nurses' perspective. Reflection and seeking support from colleagues were strategies nurses used to resolve emotional distress and validate their work. Nurses were able to resolve distress because reflection helped them to validate their own actions caring for patients and families. In this section, nurses described *reflection, looking for validation from patients' families and colleagues, seeking comfort from own family and friends, and acceptance* to maintain their emotional wellbeing.

5.4.1 Seeking support from colleagues

Having the support of colleagues was an important strategy that nurses used to protect themselves from distress and maintain their emotional wellbeing. Most nurses interviewed referred to using their colleagues, particularly those they had developed a friendship with, to debrief about their experiences in ICU: *'I talk a lot, so talking to friends in the unit . . . most of the time it's just talking to my friends at work so that we can talk freely'* (N3). Nurses spoke of wanting to talk to colleagues about work to validate their experiences of caring for ICU patients and families. It was evident that colleagues had a much better understanding of ICU nursing, and could share similar experiences and provide support,

particular when nurses wanted to protect themselves from distress. As one nurse explained when describing how they managed when there was a potential to experience distress: *'Communication with your colleagues and people that understand what you are going through. People that work with you have the same understanding . . . '* (N6).

Sharing experiences in ICU with colleagues was essential to nurse wellbeing. Reflecting with colleagues was used to express and explore feelings that nurses experienced in the ICU. It was effective because nurses were able to share common or similar experiences. Nurses needed to explore episodes of care to reassure themselves that they had done the best they could. Supporting each other in this way helped nurses resolve feelings that may have caused distress and was therefore protective. Sharing feelings was an effective strategy when it was with someone who could comprehend the experience:

Most of the time for me I think I do discuss it with my colleagues, that would probably be the main way that I express the way that I am feeling or the way I have dealt with something. . . . if you do take it home with you, if you try and discuss it with somebody else, in confidence, like if you try and discuss your day with somebody who is not medically minded, whether it is your partner or parents or whatever, I think that it is almost not worth doing it. Like they don't have the concept or the understanding, not being able to understand what you have actually dealt with in your day. So mostly, I find discussing with colleagues is more beneficial. (N15)

One of the reasons that colleagues were so important for support was the type of incidents that nurses needed to share. As explained by one nurse, the situations that ICU nurses were confronted with events that were extreme and infrequent in most people's lives. Talking with people who understand the situation and how nurses felt in response was important:

Well in those situations you can only really talk to the people who you know actually understand it because I think as nurses you see the extreme of human behaviour especially in intensive care. (N10)

Debriefing was recognised as a strategy to maintain emotional wellbeing and it protected nurses by allowing them to acknowledge their feelings, unload themselves and move on:

I think probably debriefing is quite an important thing and I don't know if we do that properly. I think we allude to it a bit. . . . With each other, maybe with senior staff, maybe doctors. . . . I think to get it off your chest with people who understand the work environment and then leave it there. (N12)

Friendships were also described within the ICU that facilitated reflection. Nurses were specifically seeking to resolve negative feelings to protect themselves from distress. They stated that they were able to explore feelings with colleagues who were also friends: *'I have got friends that I work with who are in the same unit, so we are able to discuss amongst*

ourselves to make that easier, to deal with the problems. . . . ' (N15). Nurses described feeling vulnerable when wanting to express their feelings:

As long as it is people you feel understand where you are coming from and you will be confident enough to divulge because when you do that you expose a part of yourself and that is where people become fearful. They are exposing that vulnerable side or you are sitting down and you are both having a ball of a cry. Like even in here one day sitting with (name-consultant) I sat here and cried and (name) himself was crying, you know I don't have a shame about crying . . . it is an expression of an expression and if you don't let it out that way, it eats you and you've got to let it out (N6)

Nurses identified differences in the way debriefing was undertaken, particularly the gender differences that may impact the nature of sharing support. However, the outcome was the same:

I would probably say that I would talk more to the women than the guys. The guys, it is more jovial, joking around, where as probably talking to female colleagues, they would probably be more sensitive and they would understand things I guess. . . . It does help but not only with the boys. I think it is a global thing in ICU that helps a lot. It is a strategy that everybody uses to cope. I think it (debriefing with colleagues) is (done) subconsciously. We are able to do that in intensive care and it does help and I guess it does seem funny even when you joke about bad things that are happening, I guess what you really notice is that it is not intentional; it is just a coping mechanism. (N14)

Humour was used in context with situations that happened in ICU and was really only effective with colleagues who understood that context. Humour was also used to facilitate debriefing on difficult emotional issues:

Being able to have a supportive network where you can discuss that sort of thing and I think that is probably why nurses have the most dark sense of humour, the most warped sense of humour, because it's a way of dealing (with it). And a lot of people don't understand that at all, some people, especially in a social situation I think you need to be very careful that some of the things that you say obviously would sound very, maybe inappropriate to people. But I think it is a way of being able to debrief and talk about those emotional things that go on at work. (N10)

In the following exemplar, the description of debriefing signifies attempts to remain 'grounded'. In recognition of the role they play at very critical times in individual lives, nurses have to remain level headed and clear thinking. When they know they have had an exceptionally good experience, they also seek clarification and grounding to understand the positive impact they felt they made. Nurses seek to validate their work, keeping a check on what they are doing and how they themselves respond:

I need feedback on what I am saying, I need you to tell me what you're hearing. . . . I have two friends in particular who are very good that way, I listen to what they are saying. . . . I am not asking for anything about my care because I know that I

have given the best, I am asking about my head, I am asking them to give me feedback on . . . am I dealing with it ok or am I going too deep into this or am I too heavy as I say (laughs). Tell me where I am at and I have been put in my place, twice, which I needed. A good kick in the arse, and that is fine. . . . Whether I thought I was so good, probably that was what I thought I was over the top with . . . I mean anybody else could do just as good a job as me, why do I think I am any more special than the next person. (N6)

Remaining grounded was essential to wellbeing to gain understanding of the things they have dealt with and in particular, how they have reacted to situations, especially when they are feeling very good about their role. They try and keep things real:

We do reflect a fair bit in intensive care with each other, not reflection yourself but just bouncing ideas off one another, other staff members and that is probably a fair bit of outlay. . . . Not from an anxiety point of view but just to discuss it and probably see if they see, see the same things happen to them I guess it does. It is always good to figure out . . . if people are on the same wave length as you. . . . (N14)

Reflecting on nursing practice and the complexities of patient/family care emerged as an essential activity for nurses in ICU. Nurses interacted with many patients and families in crisis, often at a time of life and death decisions. Nurses had to reflect and debrief with colleagues to make sense of their role and put their role into perspective. Nurses used reflection and debriefing to validate their care and sought to understand their own actions/reactions to patients and families in ICU. By validating the care they gave and understanding their own actions/reactions within the ICU context, nurses could protect themselves from suffering or distress.

5.4.2 Reflection

The nurses interviewed described using a process of reflection working in the ICU. Reflection is described as a process of contemplation, an attempt to understand complex or troubling ideas that don't necessarily have a solution or outcome (Moon, 1999). Reflection has the ability to change understanding or knowledge and is a way of reconciling troubling thoughts or experiences (Lockyer, Gondocz, & Thivierge, 2004) Using reflection was commonly described and nurses identified that it was a helpful process:

I find I do a lot of self-reflection, a lot of . . . a lot of thinking about what I've done or you know . . . could I have done anything different or those sorts of things I think help as well. (N3)

Nurses described how they reflected and searched for meanings that helped them understand an emotional incident. In these descriptions, the meaning and understanding they derived was usually of a philosophical nature. They also described their personal

response to the emotional distress of patients and families and how reflection enabled them to move on from suffering:

I probably would think about them a little bit when I go home. . . . It just makes me realise that even though we are nurses we are not invincible to everything. . . . We tend to feel, even though you try not to we still do. . . . I think that it just means you have obviously got a bit closer and obviously, their lives have impacted on you. I would have a bit of a cry and then maybe have a think about it. (N8)

As one nurse explained, reflecting on the day gave the opportunity to review the day and identify situations that were stressful and the nurses own response to these. This nurse spoke about reflecting on reactions to stress and aligning practice with personal values. Applying guidelines for practice to work within provided nurses with boundaries that were protective of distress:

I guess for me it's more about having a better sense of how I cope in stressful situations, even identifying what a stressful situation is for me. . . . It's about having a set of personal values as well and really trying to work within those. (N9)

Nurses described using reflection on their own and with their colleagues and it was used to comfort themselves when they were feeling emotionally upset or questioning the events within the ICU: *'It's one way of reflecting in ICU, for staff, you go to the tearoom and discuss it in the tearoom and it might make you feel a bit better as well'* (N14). Using reflection was described by nurses as a process that they had learned through experience and was also used to validate their care and responses to incidents in ICU:

For me it's a lot of reflection. It's a process I very much go through. . . . Yes, although I almost needed someone to be able to say to me 'this is something that you'd find really useful. This is what you need to do'. . . . It's just as I've gotten older and I've had a lot more experience. I find it's a way that I work through lots of issues. (N9)

Reflection was acknowledged as a helpful strategy to maintain emotional wellbeing working in the ICU. The participants used the process of reflection either on their own or with colleagues and it was an informal part of teamwork in the ICU. Being able to reflect on their work protected nurses from experiencing distress because this helped them to validate the care they gave to patients and families.

5.4.3 Looking for validation from patients' families and colleagues

Giving best care and having that care validated was an important part of ICU nursing. Validation of care as positive feedback was good for the nurses' emotional wellbeing and as previously described an incentive to keep nursing. Nurses described feelings evoked by family responses and demonstrated that the impact of families reacting positively was good

for nurses' wellbeing: *'I think if you have got a really positive family and they are really appreciative of what you are doing . . . (it) really makes a difference'* (N8).

Nurses in this study described themselves as needing feedback, particularly from families of patients that they were being seen as effective in their care. If feedback was not forthcoming then nurses actively sought to receive it. It was important for nurses to demonstrate that they cared for the patient as a person and thought that providing a high standard of nursing care that was visible did this. The response that was then forthcoming from families validated the care and nurses felt comfort from this:

I just like to know that the family can see that we're caring enough to look after the patient, making them look nice and clean, smell nice . . . just all those little minor things so that the family also don't focus on all the technology that's around them and know that we are caring and not just focused on the ventilator, the pumps, you know what's going on. (N2)

Forming a relationship with the family was better for the nurse, and when this was not achieved, they looked for other ways of demonstrating care to the family and they felt more defensive about their nursing care. Nurses needed to know that the family were happy with the care of their relative and when it wasn't available, they tried harder to get an affirming response from them:

Some families, their family member is really sick and . . . they won't even come in and visit. . . . I find that sometimes a bit hard because that is not what I personally would be like. . . . I have to respect their decision and . . . probably a family like that I probably don't relate to as much. . . . You don't form that, you don't get chatting about other things, even about what the patient was like previously. . . . I suppose it doesn't affect my care of the patient, but it probably affects the way I talk to them. . . . So you just have to gauge their questions and their reactions to when you say things. . . . you have got to try and convince them that you are not doing anything bad but that can be quite hard. (N8)

Affirmation of doing a good job was also sought from peers and ICU colleagues, particularly senior doctors and consultants. Nurses used their experience to make important decisions and they sought reassurance that they had made good decisions:

If it involved medical staff then I speak to one of the consultants that's on because that's a way of me dealing with it and getting their affirmation that it was the correct thing as well, so I knew that I was ok in my judgement . . . just that affirmation that everything is alright. (N3)

Nurses also looked at things such as whether they were allocated the most critical patient as that affirmed that they were thought of as competent by their peers. Feeling valued was demonstrated in the data as being very important to wellbeing. It was part of self-esteem and they were vocal in looking for reasons for patient allocation that validated how well

they were thought of. Nurses constantly assessed all situations, seeking affirmations so that they could acknowledge the positives. In the following exemplar, the nurse moves from frustration to feeling that she was well thought of and her expertise was validated. Accepting this led to role fulfilment and had a positive impact on wellbeing:

When the unit turns into a high dependency unit because there are no ward beds and you're looking after awake, agitated, aggressive, non ventilated patients day after day after day . . . that becomes frustrating. . . . I have a look around me and realise that there's a junior staff member with relatively junior staff member with a sick patient, so I'm put there to support them and I go 'OK, no problems,', take a bit of a breath, everything's alright. (N3)

There were many situations where nurses sought to have the work they had done validated as well done. In the following exemplar, the nurse had attended to a patient in cardiac arrest in another clinical area. The control of the arrest had fallen to this particular nurse and immediately afterwards no-one had come forward with thanks or praise. This nurse was left to speculate and question the responses of others to this nurse having assumed control and suffered doubting, nagging feelings of discomfort. The nurse then explains his/her reactions to comments that came back the following day:

I would have wound down I think, and I wanted someone to tell me that I had done a good job, that was what I wanted actually. The next day our CNS said to me 'oh, I heard you were wonderful yesterday' and I said 'oh really' and she said 'we just had a CNS meeting and everyone said that they were so glad that you were there, that you controlled the situation' and I was so thrilled, that really made my day, yep. So I wanted someone to say well done, and I wanted someone to say wasn't that awful. So I wasn't looking for praise, or I was a little bit, but someone to acknowledge that it had been hard and ask us how we felt I suppose. (N12)

It was important for nurses in this study to feel valued. Experiencing validation made nurses feel good about themselves. When nurses were experiencing emotions such as emotional distress or suffering, one of the processes they used to overcome this was to seek validation that they had given their best care.

5.4.4 Seeking comfort from own family and friends

Nurses talked about days and events at work that they did discuss with their family. As the following exemplar demonstrates, the reason nurses felt the need to discuss things at home was because something happened at work that was emotionally difficult and had created suffering. They sought comfort by sharing the fears raised with someone that was close to them:

I reckon the stress I take home the most is when I see people that I can relate to like a might see a girl sitting next to a sister critically ill and I think of my sister or I might see a young boy who has been out driving in cars and I think about my boys. . . . That is probably my main one at the moment, with young boys and cars or I come home and tell my husband and he cops it, so I off load it on him. I tell him and I think it has also changed his life me coming home telling him all these things because he just knows life isn't a given and that anything can happen. . . . I don't know how I used to do it but at the moment I would think about it a bit, talk about it with my partner and once I have said it I feel like that's enough and I can move on. (N2)

Comfort provided by close family members was at times the only way to reconcile the feelings and emotional responses triggered by the events in ICU. In the following exemplar, the nurse is describing a very emotional experience of caring for a family whose adolescent child passed away following an accident and then went to theatre for organ donation:

I was very quiet and I had a couple of red wines, not a lot, like I think I had 2, and (name), my partner said to me 'oh you seem a bit quiet' and I said 'yeah I had really bad case' and I talked to (my partner) a little bit about it but I think being around (my partner), he/she didn't get it and not being in the medical profession, he/she didn't get it, but you know he/she listened. . . . I talk to my mum a lot, she is a nurse as well and so we have that mother/child confidence (laugh). So I talk to her a fair bit and she is a good support, she understands everything, so that is nice. But most times and like I said, I haven't had one for a little while most times I can rest back on the fact that I have, that I am doing the best job that I can by my patient and I am confident in my own ability and the support that I am giving the family, so that I can go home and know that the best has been done. (N4)

In some circumstances, ICU nurses managed to hide their emotional responses to some situations. Nurses described themselves as controlling their emotional responses at work, particular if they were suffering deeply and chose to express their sadness/grief at home. Once they were home they chose to share these responses with their partner or someone close that could provide comfort:

These type of things I usually keep to myself, it is not a thing I feel comfortable reflecting with other people at work. Maybe at home with my partner, cause (he/she) understands me a little bit more, but maybe when these things happen I try to keep them to myself. (N14)

Most nurses acknowledged that there were times where they had to share their suffering with family and friends at home. This process then enabled them to move on from it and function back in their home life: *'I tell the kids about or tell the boys about it I have got to talk about it and then I've just got to let it go'* (N13). Most nurses interviewed stated that there were times when comfort was sought: *'I'll say to (partner) 'oh I had a bad day''* (N7). Nurses did not want sadness or suffering at work to dominate their home life. They did described some days at work as 'traumatic', indicating that they had felt emotionally

traumatised by work. Some nurses needed to let their families know this had happened, perhaps to be given the space to process their emotions themselves: *'There are the times when I do go home and I have had a traumatic day when I do try and express that at home'* (N15).

For ICU nurses, family and friends played an important part of processing difficult emotions. Nurses described instances where family and good friends could pick up instinctively that they were suffering and set about providing comfort. Nurses relied on this to overcome their sadness:

They will pick up on, 'you've had a difficult time at work today,' or 'we've noticed you're a little bit down.' And they don't even often have to ask about what. And especially when sometimes you really don't want to say about what, it's something that you're still processing. And they will say 'we're just going to do something nice,' and I'll just continue to process that myself. (N9)

The participants in this study described times where they were suffering and sought comfort to manage the emotions experienced when working in the intensive care unit. Most nurses identified close family, close friends/colleagues as the reliable people that they sought comfort from. Nurses also explained that close family and friends often perceived that they were suffering in response to their work in ICU and could be proactive in providing support.

5.4.5 Acceptance

As previously described, many patients admitted to the ICU were there following a trauma or sudden illness. Nurses could not question why these things happened; they accepted that this was the nature of ICU. Throughout the data, it was apparent that nurses tried not to ask or answer the philosophical questions surrounding the patient's admission and tried to focus on best care. Nurses had learnt that focusing on the events leading up to the patient's admission did not resolve the patient's dilemma and could cause distress for the nurse. For example, nurses experienced frustration with young patients following trauma or drug overdoses. Accepting that the patient was there and looking forward to managing the care of the patient was a strategy that experienced nurses used to deliver best care in these situations:

I just feel sorry for them, because I think you just deal in the now, you can add in the background, it makes you more compassionate but it just makes you annoyed that you can't stop them, it's a waste. (N12)

Nurses tried to see that nothing they could have done would have prevented the patients and their families from being in their current situation, *'the other thing that I look at is that*

it's their time and I have to accept it' (N6). Acceptance was described by nurses, not allowing themselves to think beyond the present moment with patients and this protected them from feelings that were emotionally distressing: *'And some things I just have to accept that that's a part of what is inherent to Intensive Care nursing'* (N9). Part of the self-talk was to reinforce in their own minds that they were not responsible for the outcome of the patient. In this way, nurses validated their care of the patient and kept their role in perspective. Being able to do this was described by nurses as something that they had learnt early in the ICU career, and they also continually reinforced this to themselves and their colleagues. This process, learnt by experience, helped them to function in an advanced skilled environment under pressure and not fall apart emotionally.

Being able to separate their own emotional responses to the patient allowed nurses to protect themselves from distress and fulfil patient care goals. Nurses could acknowledge the sadness or frustrations; but blocked the feelings of consuming sadness, frustrations or anger and still recognised that their role was positive in the scenario of the patient: *'so I felt good in one part and sad in another part . . . '* (N6). This psychological process also allowed nurses to feel good about their job, acknowledging some sadness without hindering them in their role as a nurse. They just accepted that the patient was there: *'A patient is a patient, they are in ICU and they're there for a reason, they are all the same really. . . . In ICU, I don't have a problem (accepting)'* (N14).

Nurses described themselves as taking a philosophical approach to the patient and the events that led up to the patient's admission. Nurses protected themselves from distress and used this strategy to remain calm at the bedside. Nurses were confident that their care was the best they could do and that any poor outcomes were attributable to the patient's illness, not sub-standard care:

I always think I keep calm and I don't know physically how I do that, but I always do manage to keep calm. . . . I do feel calm and I figured this out a long time ago, it doesn't matter how worked up I get or how, how quick I get in a situation, I've not got any control over the outcome. . . . So I found that out a long time so it doesn't matter, whatever I do, how good I am, how bad I am, you know there a lot of other people involved and it won't make any difference to the outcome and knowing that makes me feel calm. . . . I think it is good for people to see that as well, you do get a ripple effect and I can see that in other situations, where people get heated up then everybody ends up the same. (N14)

Drawing on their experience and remaining calm protected nurses from suffering anxiety and blame for the situation of the patient. It also enabled nurses to remain in control of their actions and feel confident that they had given exceptional nursing care. Nurses in this study demonstrated that they had learnt to look at the big picture and reinforced this

through sharing their experiences with colleagues and validating their care. Therefore, nurses minimised the impact or protected themselves from experiencing emotions such as anxiety, regret, remorse and fear for the outcome.

In summary, nurses sought to validate care episodes through strategies such as reflection, support from colleagues, validation from families, comfort from their own family or friends and acceptance. These strategies were part of the process of protecting themselves from distress and how they maintained their emotional wellbeing.

5.5 Distancing Self from Distress

Nurses used some strategies that have been grouped under the theme of *Distancing self from distress*. Distancing refers to strategies that created a physical or psychological barrier between the nurse and experiences at work that were actually or potentially distressing. Nurses used psychological activities such as distraction, listening to music and emotional barriers. They also used physical activities that separated them from distress such as taking breaks and symbolic gestures that created a space between work and home life such as 'taking off a coat' on re-entering their home. Mostly, distancing strategies were helpful activities that helped nurses care for their own emotional wellbeing. However, there were some times when nurses experienced distress where distancing became extreme. In these circumstances, nurses felt overwhelmed and the desire to distance themselves became an inability to care for some patients or a desire to leave ICU nursing altogether. *Distancing self from distress* is described under home activities including Music on the way home, Taking off my coat, and Self-caring activities. Nurses also used distancing from distress at work and these are described under categories including Using distraction, Taking a break, Selecting patients and Leaving ICU.

5.5.1 Music on the way home

Nurses described strategies that separated their work life from home. They gave accounts of strategies that they used to achieve a transition from work to home psychologically. Listening to music on the way home was a strategy that helped detach from any negative emotions or distress they experienced at work. It was to refocus thoughts from work to things away from work. Nurses explained that they used the drive home often to 'chill out' and arrive home in a better emotional state distanced from work. The drive home was used to improve their emotional wellbeing:

I live an hour away so driving, I tend to calm right down before I get home so I'm not taking it home, and therefore my family are not inflicted with me being uptight and horrible either. (N3)

Once nurses left work for the day most described trying to not take home the emotions from work, keeping their work and home life separate. This was process of 'blocking out' and dissociating completely from the negative emotional experiences of ICU: '*. . . when I leave work or if I try to just leave work at work, I don't take it home with me. I think that is important, to have a life outside of work*' (N15). Dissociating from work allowed nurses to have a life outside of work that was not encumbered with emotional issues from work: '*Once I leave the situation I am able to block it out so it doesn't (upset me)*' (N15). Music was one way of creating a distraction that helped to block out work: '*I listen to some tunes in the car on the way home and that is how I chill out, it chills me out*' (N11).

The nurses interviewed who were all experienced, consciously made an effort to leave work behind and after most shifts. Whilst strategies such as listening to music and long drives home distracted their thoughts away from work, nurses described needing to have peace of mind. This included knowing that they had given their best at work and had the opportunity to debrief with colleagues to allow themselves to be distracted from work at the end of the day.

5.5.2 Taking off my coat

Keeping a distance between work and home was achieved symbolically by having gestures or rituals that kept work separate from life outside of the ICU. When leaving work, experienced ICU nurses spoke of symbolically re-entering their outside life:

But one thing I am good at I will drop my coat off at the door and I won't take it home if I can, cause that is really important for my psychological wellbeing and I don't like bringing things home. . . . I have made it a point that when I take my coat off I just leave it. It is just like a cleansing thing, that for me is my coping mechanism, I just don't want it at home, because I've got too much everyday life at home and I just do not want to take baggage from work home. (N13)

Nurses wanted to leave their work at work and not think about it once they were home. Many of the nurses interviewed described a ritual of re-entering their home life: '*I probably go and lie down on my bed and have a cup of tea and read my book, actually or a magazine and that is just to chill out, that part of the day is over with*' (N7). Experienced ICU nurses were able to detach from work easily: '*I tend to forget about it as soon as I leave so that protects myself as well as it is physically gone from my head*' (N5). As explained in the

following exemplar, nurses had developed a process of preparing for work and a process for returning home and this was important to help nurses leave distress behind:

It is a kind of a spiritual thing, it is just a way of dealing with it. I cleanse myself, I have a routine that I will say a prayer in the car on the way into work so that I would do everything I can for the day by my patient and that I won't injure them or do anything wrong to them, and I will ask for protection. Now whether you want to believe that is your angels or whether you want to believe that is your god or what the heck, so that I will do a good job by my patient. Right and when I have my job done and I go home I have a shower and it is like that I wash anything negative away from me so that it is like I have done my job now and I am back in my own space now. (N6)

The mental preparation that nurses undertook was described as a coping mechanism. It allowed ICU nurses to have distance from the emotional impact of being with critically-ill patients and their families. It was effective in helping nurses leave their job at the end of the shift and return mentally prepared for the next shift.

5.5.3 Self-caring activities

Nurses also identified strategies they used away from work that helped to create distance from ICU and maintain their emotional wellbeing. Caring for their physical health was felt to have positive benefits on their emotional wellbeing. One of the most common self-caring strategies used by nurses in this study was exercise and how exercise helped nurses to manage stress:

Another thing that helps me with stress is exercise, I do a bit of exercise. I don't know if that helps me directly with work stress but I think it does help with general stress. You can just let all of your frustrations out (laughs) and you can go through things in your head while you are doing it. (N2)

Exercise was described as having several functions including relieving stress. Whilst the stress relief was not always stress related to work, being in a stress-free state going to work was recognised as important to maintain wellbeing:

I mean exercise is a big way that I, I deal with this (stress) and when I say exercise it's actually walking and it has to be on a beach and it would have to be for two hours. . . . The other thing that really helps me is also involvement in other things outside of work so you don't become completely bogged down and, not being able to sort of shift from that mind set. . . . Self-care is also about having a really good support social network of people that you feel good around as well. I think that's the, probably the biggest thing for me. (N9)

Activities outside of work and interactions with people that were not ICU related also gave nurses the opportunity to put things from work into a different perspective: *'I did groan a lot when I was swimming that night. If somebody had the misfortune to ask me if I had been*

at work and I said....'oh, I had the worst day, blah, blah'. . . . It is quite funny when you look back on it really, because it probably wasn't that bad' (N7). Having the opportunity to take time for self and exercise was important and most described an exercise that was solitary and allowed time for reflection. Nurses also needed to have interests away from work that were not related to the work of ICU: '*Going and doing something different outside the unit*' (N3). Having outside interests also gave nurses something positive to anticipate when they were at work and whilst they activity provided enjoyment, anticipation provided a distraction when needed at work: '*I try to always have something to look forward to I suppose*' (N8). In this study, nurses also spoke about undertaking activities that promoted relaxation and was used in combination with reflection:

I have been doing meditation and Tai Chi for a long time. . . . I think it makes me realise that I have done the best I can and I can't do anymore and that is all that is expected of me and for me to think that I can do any more is unrealistic. . . . I just find that the massage is a great relief, mind you I have a spa as well, I kind of veg in that . . . it is a relief. I think that it is important that you let it out of your cellular, cellular membrane, an interesting concept, but you do, 'cause if you don't it stays there. . . . It is a kind of a spiritual thing, It is just a way of dealing with it, kind of like I cleanse myself. . . . I need time out for me, I go for a massage once a fortnight and I go for a facial once a month (N6)

Nurses recognised that they used self-care strategies and that some of these were used as a means of escapes from the mental anguish or suffering that they were experiencing. Nurses also understood that their strategies changed depending on their situation:

Go home and play with my kids, take my dog for a walk, put the walkman on and read. I tend to do these things now to take me away from the situation whereas before I may be used drugs and alcohol. (N11)

The participants in this study talked about suffering at home and part of processing that suffering was to use alcohol to find some relief. It was more commonly described as a strategy when they had looked after a particularly distressing patient and family. Nurses stated that they had focused more over the years on strategies that relieved suffering before they got home:

And I think sometimes that you tend to go home and you have a glass of red and probably you are a little bit on it because you are human and you are going to, but they're the ones that kind of play on your mind. I think that that has probably improved like, over the years, like when I was more of a junior ICU nurse I would take it home more. (N4)

Alcohol was referred to as self-care activity that relieved suffering, however it was usually in conjunction with talking to family:

I might off load while I am sculling back a wine (laughs) just one or two helps you to relax. . . . and that is probably helps with the emotional side of work as well as the stresses of general life really. (N2)

Enjoyment from being with family, particularly caring for children and animals was an activity that nurses identified as helping to care for themselves away from ICU. Interacting with people they cared about was important for wellbeing:

What I usually do is go for a walk, with the kids and the dog, get out in the sunshine or do something physical, I play basketball so, so I play basketball if it is my day for basketball. Usually I go for a walk. And coffee, love my coffee. (N12)

Sometimes there was just no escaping or any possible way of blocking the intense emotions experienced when someone dies. Managing the intense grief of family when they lose a child was always described as traumatic for nurses and at times they grieved for the loss. Nurses at these times experienced considerable suffering and sometimes the strategy that alleviated this stress was intense. One nurse talked about an experience of considerable suffering and described 'screaming' in response to a tragedy that had left her feeling angry:

I have walked the beach and screamed into the sea after one bad episode here, that was to release an awful lot of. . . . I was annoyed with life or annoyed with God or annoyed with whoever you want to say because of a tragedy that happened and I dealt with the parents and I just thought 'why is this happening to them' and I did screech into the sea and I walked and screeched into the sea and I got that off my chest. . . . I laughed, I felt better, it was like I started to breathe deeply and take in all of the goodness and get rid of the anger, because it is very important. But I visualise things, I walk with a visualisation in my head. (N6)

In this study, experienced ICU nurses recognised that some of their emotional responses had the potential to have considerable impact on their home lives and that was not desirable. Nurses had developed definite strategies that enabled them to disengage from the emotional responses that were negative and tried to only acknowledge those experiences at work. Nurses used self-care strategies to maintain their emotional wellbeing and care for themselves away from the ICU. Nurses recognised that self-care strategies helped minimise distress they experienced as well as managing stress in general. Taking care of self-assisted nurses to be resilient and minimised the distress they experienced as a result of their exposure to patients in the ICU.

5.5.4 Using distraction

Distraction as a strategy to protect nurses from distress was used most often in relation to the emotional suffering of patients and their families in ICU. Nurses actively sought to shift thought processes from dwelling on sadness or distress and avoid feeling those emotions

personally: *'I felt like I, sometimes I really hold in tears and I think . . . focus on the patient, focus on supporting the relatives'* (N4). When that was difficult, the nurse described a process of recalling a happy experience that was a distraction from distress: *'focus on when my team won'* (N4).

Nurses also described chatting and 'having a laugh' with colleagues in the ICU as a way of distracting themselves. Having a social context with colleagues within the ICU provided an atmosphere for each other opposite to what they were often dealing with. Maintaining a lighter atmosphere within the ICU was achieved by talking about everyday activities and this had a positive impact on wellbeing:

I like the fact that you can have fun as well as work hard and help each other. Just chatting about general everyday life, I guess that's one way, going back to what we were talking about before, going back to the emotional stress, and that's one way of coping with that, we don't just stand around morbidly thinking about the horrible situation that's in front of us. And that's probably how we deal with it the most while we are at work, that we just make jokes and people might think, people from the outside might think we're being insensitive but it is just a way we all cope with the sad situation. There is no use standing around all day being miserable because you would never be able to go back the next day. (N2)

The use of distraction was apparent throughout the interviews as a way of psychologically distancing self from distress in ICU. Being able to turn away from the patient/family for a light-hearted interaction with a colleague was a distraction. One of the factors that made distraction easy for nurses was the ICU environment, where nurses worked in close proximity to each other. Nurses also spoke about deliberately trying to be good humoured which was beneficial to themselves, colleagues and when appropriate, families of patients:

I am very jovial at work, I laugh and make jokes and sort of have an aura of fun, and I suppose that is what I do to protect myself. I banter with everyone and it is all very light hearted, I make little light hearted remarks with my colleagues, with the relatives if it is appropriate. I am like that, if it is not appropriate then I can be serious or whatever is needed really. (N12)

Having the opportunity to chat and have some fun provided a mental space to escape to for all staff and a temporary relief from the intensity surrounding patients/families when they were distressed. Nurse acknowledged that the ICU could be a 'sad' place often and the sadness could be obtrusive throughout the unit. Nurses focused on creating an opposite mood, something that nurses described as being protective for them and as a way of coping with the reality of their work. This nurse further explained how this type of distraction worked in contrast to the reality of critical illness and consequent suffering. Having this aura of light heartedness and humour prevented the nurses on any given shift being drawn

into a collective suffering. Promoting a positive atmosphere was something that was done for emotional wellbeing.

Another way that nurses distracted themselves was to focus on the parts of care that they knew would be effective. For example, they would focus on exceptional basic nursing care of the patient. Focusing on basic nursing care made nurses busy and gave them a purpose that distracted them from feeling sad and was a strategy described when caring for patients who were not going to survive ICU:

I think you're more determined to do your best, to make things more positive for you, it's upsetting but you've got to really not feel bad, you've got to really look after this lady, you've got to brush her hair and her teeth and have her beautiful for her little baby. (N12)

The nurses interviewed described using distraction as a strategy that enabled them to continue caring for the patient and protected them from distress. Nurses liked to maintain an atmosphere within the ICU that was social and gave nurses a haven to divert their attention from distress. This strategy was most often described as being used when the situation with the patient and family was particularly sad. At times, nurses actively diverted their attention to focusing on basic nursing care because often this was what was best for the patient and the nurse.

5.5.5 Taking a break

Another strategy that was common for nurses working in ICU was to take physical breaks from the bedside. Taking a break referred to time away from the ICU, anything from a prolonged meal break to actively planning days off between shifts and regular holidays. Planning days off and holidays were ongoing management strategies used by nurses. There were also times at work where nurses described needing to 'take a break' from the bedside to get distance between themselves and patients and their families. The purpose of time away from the bedside was sometimes just an immediate release of the tension surrounding the distress of families, or to seek a temporary break from a complex patient.

Planning days of work against days off was described by most nurses as a way of managing work/life balance. Most nurses interviewed spoke about the roster pattern they requested and stated that they liked to have several days off between shifts. This was easily achieved by part-time workers who stated that their deliberately planned roster patterns and days off to allow time for rest and reflection:

I have enough days off, because I only work five days a fortnight there, I have enough days off to be able to put it into some sort of perspective and be fresh and ready to go again for the next shift which was a week later. (N9)

Taking breaks was a way of maintaining a work/life balance which had a positive impact on emotional wellbeing. Balance was achieved in one of several ways and depended on each individual nurses own personal needs. Working a combination of shorter shifts and fewer shifts per fortnight was described by some nurses as facilitating work/life balance:

By working seven hour shifts, so they're limited and I don't feel like it's taking up the whole of my day. Also by only working five days a fortnight as well, I think that probably my stress levels on this conversation might be different if I was working more hours or fulltime and I was working 12 hour shifts. (N9)

One nurse described needing to know that regular holidays were planned with the deliberate intention of being protective of feelings of *burnout*:

I do take my holidays; it is the one thing that I will acknowledge. Every three months I take a break. . . . I will book holidays in advance so that I will continually have breaks so that I do not burn myself out. I work my 5 shifts and if I find I need a break I will actually ring in, I need a mental health day. (N6)

There were also times during a shift when nurses needed to take a break, usually when dealing with distressed families. This usually referred to an extra or extended tea break, when they felt upset:

He didn't die for three or four days but that was, it was something I had to prepare myself for because I knew that it would happen. I had to take time out, I had to go for a coffee, 'I'll be back', go and compose myself and come back again. (N3)

It was also an accepted part of ICU nursing, and colleagues were accommodating of each other's needs. Nurses offered to give each other a break:

I know when I see other colleagues doing it and I have said to them, and I can see, you can always see when someone is really struggling as well, I have said to them 'any time you would like to take a break' you know even if it just a little break to get a cuppa. (N4)

Nurses described wanting to help their colleagues: *'Being aware of what is going on, not just in your bed area, somewhere else and just stepping in to help if you need to or giving somebody a bit of a break if they are having a bit of a hard time'* (N7). It was described as being part of the team. In the ICU, patients can rarely be left unattended due to the nature of care required. Having time out was essential and nurses needed to offer these breaks to each other:

It is up to you to verbalise and say look 'I need a break from here or I will go off my head' or 'this family are very demanding, I need a (break). I will have them springing off the entrance if someone doesn't relieve me'. (N6)

Breaks were seen as an opportunity to escape for a few minutes. Nurses often talked about taking a breath or time out and then being able to continue their job. These moments were essential to wellbeing:

Sometimes it can just take you out of the situation for 10 minutes or quite often what I will do is I will go and sit in the coffee room, if I feel that things are getting on top, I will even go and sit in the coffee room for five minutes, sit doing nothing nursing related and then it tends to clear me a bit. Or sometimes I have seen myself in other hospitals just locking myself in the linen room for five minutes, just to sit and be and try and calm myself down. (N11)

Creating a physical distance, even for a short break was a successful strategy for nurses to re-gather their self-control:

I just went for an early morning tea break and anyway the day progressed, it got better, but I had to take myself aside and calm myself down, I just took myself away for a few minutes and calmed down. (N7)

Through experience, ICU nurses were able to pull themselves quickly into control: *'Well you just have to suck it up and then get over it'* (N12). The nurses in this study the ability to refocus their attention so as not to get drawn into suffering. Using an opportunity to take a break from the situation allowed nurses who were distressed to acknowledge their suffering and move on:

No, I just had a cry, I had a cup of tea, I think whoever was coordinating gave an extra ten minutes to go and do whatever and I was fine. I just had a little cry and a cup of tea and just got back to it. You just switch off, you get sad, deal with it, go to the loo, deal with it and come back. (N12)

The tension some nurses experienced with patients was summarised in the following exemplar and the process of taking a break was enabled once the patient had died and the relatives had left the ICU:

When they actually go down to theatre and the relatives have gone with them, the donor coordinator, and they're not planning to come back, the relatives are gone, you've said your goodbye's, even given them a hug or something like that, so they have actually gone (long pause) I feel like I can finally take a breath, you have been sort of shallow breathing for 12 hours, you feel like you can finally take a sigh and relax I suppose. (N4)

Nurses needed physical breaks to give themselves the opportunity to maintain their emotional wellbeing. Taking a break incorporated seeking a work/life balance which was important to give nurses the opportunity to have a life away from the ICU. The types of breaks included planning regular days off and holidays. In addition, there were times when nurses needed an immediate break from the bedside and this was taken in the form of an

extra or extended meal break. Nurses needed to feel removed from the ICU to rest and reflect on their nursing care.

5.5.6 Emotional barrier

Another process nurses used to distance themselves and continue care was described as an emotional barrier. Nurses used the term 'emotional barrier' to refer to a process of emotionally blocking the sensory information of distress so that it did not affect them. The nurses interviewed stated that they blocked out the suffering that they were exposed to protect their own wellbeing:

I think we always put up a barrier and I think like most of the time when you look after a patient. . . . You always have some sort of barrier to a degree against what you are doing and lots of times you just block it out really. And you don't, you know you think about it for a while but then you just have to forget about it to because if you stayed thinking about that situation, if it was you in that situation then I am sure you wouldn't cope. (N15)

Nurses described self-talk to reinforce the barrier and overcome their own struggle to block the emotions displayed by the family. As one nurse explained, seeing people within ICU suffering was a reminder of episodes of sadness or suffering in the nurses' own life. Being taken back to these moments at work was a hindrance and an emotional barrier was used to block this from happening:

I can feel myself kind of putting a bit of, I suppose, an emotional barrier up, it is really hard like if you have lost someone close to you, it is really hard then to not look at someone who is absolutely hurting in moments like that and not feel that same grief, even go back to your own personal grief and so when I do that, when I can feel that my patients are really losing it like that, I just go back to my own experiences and that really hurts and in doing that I really kind of, I kind of struggle. I felt like I, sometimes I really hold in tears and I think 'no, no you have got to hold it together now' and I probably kind of put up a bit of an emotional barrier and think 'you can't personalise this'. (N4)

This strategy enabled them to focus on giving best care that included the family. Nurses needed to maintain an emotional distance from the patient and their family and still be caring. Developing a professional 'persona' with rehearsed responses to families was one way of maintaining an emotional barrier. Nurses described experiencing empathy and actively discouraging themselves from becoming emotionally involved with the patient or family: *'most of the time I sort of put my nurse hat on in the car on the way to work'* (N12). Having this separation was a strategy aimed at protecting themselves from becoming personally involved with the family. For many nurses this involved being seen as a professional, not the individual:

I like to keep people at a little bit of distance in terms of when I practice because I think the patient and relatives need to see that you are part of the institution and that you have a level of professionalism. (N10)

It was a process used to create a barrier between the patient's family and the nurse:

. . . That you are detached. You don't need to get involved sympathetically with patients and relatives; it is more of a professional empathetic response. . . . I have seen people get a bit too involved with family. . . . they have got other support mechanisms and I think being able to provide obviously an intimate level of care and not obviously get too involved with the family. As a protective, mechanism I think sometimes you have your own sort of spiel that you rattle off in terms of experience of intensive care. You have a common thing that you say (to families). It helps you to keep your distance. (N10)

Being able to create an emotional barrier was part of the process of distancing self from distress. Adopting a personality was described and this allowed nurses to speak to patients with a language that was part of their profession. Whilst not rehearsed, it was a method of talking to patients and families that nurses felt was professional and protected them from becoming too familiar or personal.

5.5.7 Selecting patients

At times, the nurses interviewed indicated that they felt overwhelmed by distress they experienced working in the ICU. The desire to distance from distress in ICU became overwhelming and other methods of distancing such as distraction or emotional barriers were no longer effective. Responses to feeling overwhelmed meant nurses avoided patients. The data revealed that nurses often found a type of patient distressing to care for and at times would choose not to care for them at all. They needed to remain separate from that particular patient at that time. Nurses described younger patients who were admitted following trauma or very acute illness were the most difficult to look after. Nurses found their families to be the most distressed and emotionally difficult to care for. As well as their own feelings of distress for the family, nurses were often reminded of themselves or their own family members. When nurses were reminded of their own experiences of distress, they created distance by choosing when possible, not to care for that sought of patient. These patients were likely to cause the nurse to experience distress that engulfed all of their strategies overcome and maintain their wellbeing:

I am aware of avoiding situations that particularly stir me up emotionally, like avoiding conflict, avoiding patients that, like I recently had a kid in recently who was only 13, I couldn't look after him. (N2)

The nurses in ICU recognised which patients were more likely to cause them to distress and described how they would elect not to have certain patients. At other times, nurses felt that they had been allocated a certain type of patient too often and would request a change to protect themselves from becoming emotionally overwhelmed. Nurses were very open about occasions when they selected patients to avoid emotionally distressing situations:

Sometimes I might remove myself; like I will request not to (have a certain patient) I have done that in the past. If something is too emotionally stressful, I'll actually ask not to look after that patient. So removing myself, whether that is helpful or not, don't know but it seems to be helping at the time. (N2)

Nurses explained that they sometimes experienced feelings of frustration with some young trauma patients or those following an attempted suicide. They described feeling overwhelmed with regret for patients who were admitted following an accident that involved drink driving or other risky behaviours that could have been prevented. Nurses realised that responses such as frustration and anger were disabling and that they could not care for the patient. The following exemplar came from a nurse who was explaining how she felt frustrated and upset by patients who came in following road trauma. The nurse recognised her feelings were not conducive to being able to give best care:

Because it is disrespectful and . . . if I am cranky, if I am feeling angry towards a patient then it is probably not appropriate that I look after them. And you know it's not angry, it's not outward . . . I am actively trying to understand (my reactions). . . (N3)

When nurses' emotional resources were overwhelmed they wanted to leave ICU. Nurses needed to have breaks between caring for dying patients. Being assigned dying patients too often was overwhelming. Nurses were vocal at expressing their own needs. The following exemplar demonstrates that nurses were able to stand up for themselves, to protect their own wellbeing. The nurse successfully protected self by asserting that they could not take the dying patient. The threat of having to leave ICU to protect self was real for the nurse:

I have come on and I have had like three days in a row of dying patients and I have come on and said 'nah, nah, I am not taking that patient today' (imitating ICU nurse coordinator) 'But (name) you know what it is like, we have allocated you that patient' and I have said 'I am not taking that patient today, this will be my third death in a row, give it to somebody else' 'But we have nobody else, we can't give it to this person, can't give it to that one'. And I have said 'I don't care who the hell you give it to but I am not taking it today' and I have had problems and then I have stood and said 'if that is the case then I am going home' and then they looked at me and I said 'no, I am going home if you don't change me, I am not doing this today, I have given all yesterday I cannot do it today'. (N6)

The data revealed that those interviewed believed that some nurses avoided patients because they were 'burnt out'. They had observed senior colleagues going to extraordinary lengths to select patients who were more stable to care for. In the following exemplar, the participant described observations of senior colleagues that remained working in ICU but who made considerable efforts to avoid potentially stressful situations:

I know nurses that phone up and request . . . the easier (patients) and they don't cope as good as what they should. . . . They're often more senior, it could be . . . 'burnout' they just find it difficult with certain cases. . . . It might be their coping style, their coping skills, they might be afraid that they just, it is too busy for them, they become overwhelmed and that does become apparent because you can see them asking for help and getting another nurse, this is really busy maybe two nurses would be better in here . . . Personally what I find, what I see is as time goes on . . . the nurse might start to omit different things they'll stop having like close contact with the family, it's almost like they are trying to avoid long conversations with patients and families. (N14)

The study participants commented that this type of patient avoidance whilst not common may be symptomatic of 'burnout'. Distancing from some patients at times was demonstrated as a tactic that protected nurses' emotional wellbeing in this study. It was evident however that this behaviour became necessary when nurses were feeling exhausted by having dying patients too often. Selecting not to care for certain patients occasionally was an effective strategy to manage exposure to distress or families that were difficult and therefore was protective for nurses. The data suggests that some experienced nurses were avoiding difficult patients always and those interviewed believed that some experienced nurses were not coping with ICU nursing.

5.5.8 Leaving ICU

For nurses in this study, creating distance was vital to emotional wellbeing. Creating distance may mean that nurses chose to leave ICU to protect their own emotional wellbeing. In this way, creating distance is permanent and most likely the result of being unable to maintain emotional wellbeing with other strategies. The nurse in the following exemplar described experiencing distress and the only way it could be resolved was to leave ICU nursing:

. . . The final straw for me was one night having two patients that died. So a new patient as soon as I'd come into the unit and that patient dying and then another one coming in and then after a few hours that patient dying as well. So I'd got to about 6 o'clock in the morning and the rest of the Unit was quiet so nothing else to do and, and quite a horrible, horrible time, emotionally as well. And, I was just told to go off onto the general wards just to check all of their IV drugs and, then if that was finished I could go but there was no real discussion or debrief, well not

necessarily debriefing but just discussion about what had gone on. I felt really quite, I didn't feel valued at all, it was just there was no recognition of how stressful the whole thing had been and I guess for some people it wouldn't have been. And maybe it was just a lot of other issues that had contributed towards higher stress levels for me than something I probably would have coped with reasonably well at another time but I don't know. But I found there was a lack of support for me in supporting the family. They were a big family as well. They needed lots of care and support. And I'd made specific requests to theatre for the, this particular family which were all completely ignored. And I wasn't even told that the patient had died until 2 hours later and, after repeated phone calls and I thought, 'this is just, this is just not right,' and so I resigned that day. (laughs) That was it. (N9)

In this study, nurses explained that they needed the opportunity to acknowledge, reflect and debrief with colleagues to cope with distress they experienced working in the ICU. Nurses needed the opportunity to validate the care they gave as well. In the absence of being able to employ strategies that would have been effective in managing personal feelings of distress, the nurse in this situation felt the only option was to create a permanent distance from further distress. This nurse went on to explain why distress was overwhelming:

You need to discuss those in some way and at least to have time to be able to reflect on those in a good way, and then maybe sort of have continued discussions. But I guess also I couldn't really identify anyone that I was comfortable with discussing those issues with. . . . And I don't think it was about being able to go and find a counsellor or anything like that. It was really needing to have some acknowledgement of how people are feeling. Also what I used to find really difficult was seeing lots of other nurses leave because they weren't being supported in any meaningful way as well. (N9)

Nurses in this study described strategies that relied on the support of their colleagues to overcome emotional responses to ICU patients. Nurses needed their colleagues to acknowledge distress with them in the form of support, debriefing and reflection. Without the opportunity to acknowledge their emotional reactions to ICU patients, nurses felt overwhelmed. In this study, in some situations, nurses needed to create a permanent distance from ICU nursing to protect their emotional wellbeing.

5.6 Summary

This chapter explored the basic social and psychological process used by ICU nurses to overcome the basic social and psychological problem, *Inability to Protect Self from Distress*, and maintain their emotional wellbeing. This chapter described the process that experienced ICU nurses use to protect themselves from distress and maintain their emotional wellbeing. The process, *Protecting Self from Distress*, was described under three

phases. *Delivering best care*, described when nurses had achieved best care and were able to feel happy and personally satisfied with the work they had done. *Validating care in ICU* enabled nurses to resolve feelings and share experiences that helped find meaning in their work. *Distancing self from distress* included strategies used by nurses to minimise feelings or experiences of distress. Being able to choose exposure to situations of potential distress was important to wellbeing. However, choosing not to care for difficult or complex patients often was believed by some nurses interviewed to be a sign of burnout. When nurses were not able to create, there was a risk that they may choose to leave ICU nursing.

It was evident from these data that nurses used strategies that protected them from distress. Using the strategies identified within the process of *Protecting Self from Distress*, nurses maintained their emotional wellbeing (see Figure 5.1). The nurses interviewed enjoyed their work and none of those interviewed planned to leave ICU nursing. They were maintaining their emotional wellbeing.

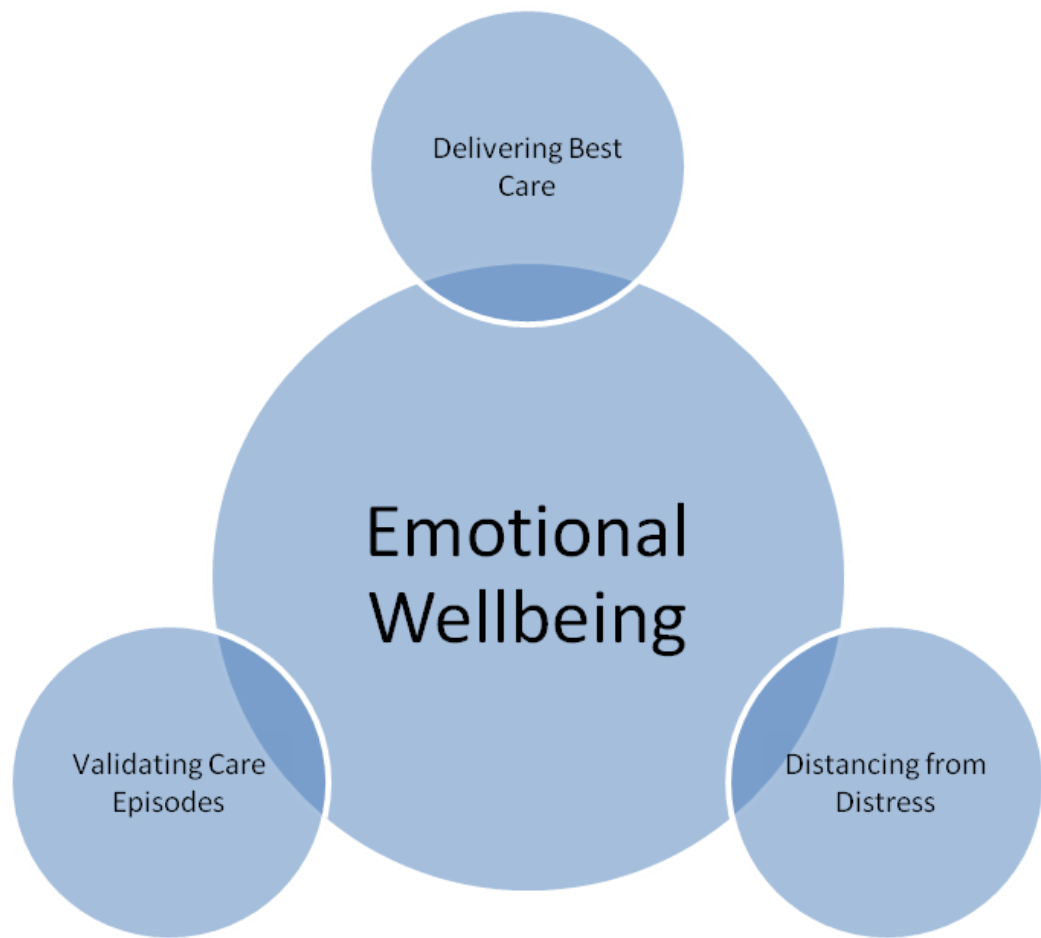


Figure 5.1 Protecting self from distress

CHAPTER 6. DISCUSSION AND LITERATURE REVIEW

6.1 Introduction

This Grounded Theory study led to the development of a substantive theory that outlines the social and psychological processes experienced ICU nurses used to maintain their emotional wellbeing. The theory explains how nurses working in the ICU manage the emotional distress of working with patients and families in crisis. The methodology used provides insight into the phenomenon of maintaining emotional wellbeing and contributes to understanding the factors within ICU that are important to nurse wellbeing. The findings relate to the nurses who participated in this study and the context in which the data was collected and cannot be generalised to a wider group of nurses at this stage. However, the findings provide directions for future research that investigate nurse wellbeing and staff retention. The context of emotional wellbeing, conditions that had a positive or negative impact on nurse wellbeing and the strategies that nurses used to maintain their wellbeing will form the structure of the discussion. These findings will be compared and contrasted to current literature.

The substantive theory developed, *Protecting Self from Distress*, described how experienced ICU nurses maintained their emotional wellbeing in the ICU. The theory, consisted of three phases, *Delivering best care; validating care episodes; and distancing self from distress*. The process identified and explained the strategies used by experienced ICU nurses to overcome feelings of distress including sadness, grief, anguish, frustration, suffering, disappointment and dissatisfaction, experienced by nurses working in the ICU. If nurses were not able to protect themselves from feelings of distress, they were not maintaining their emotional wellbeing. This was the core problem and was called *Inability to Protect Self from Distress*. This study also identified conditions that helped or hindered nurses to protect themselves from distress and maintain their emotional wellbeing. This theory, including the phenomena, process, core problem and conditions is represented in Figure 6.1.

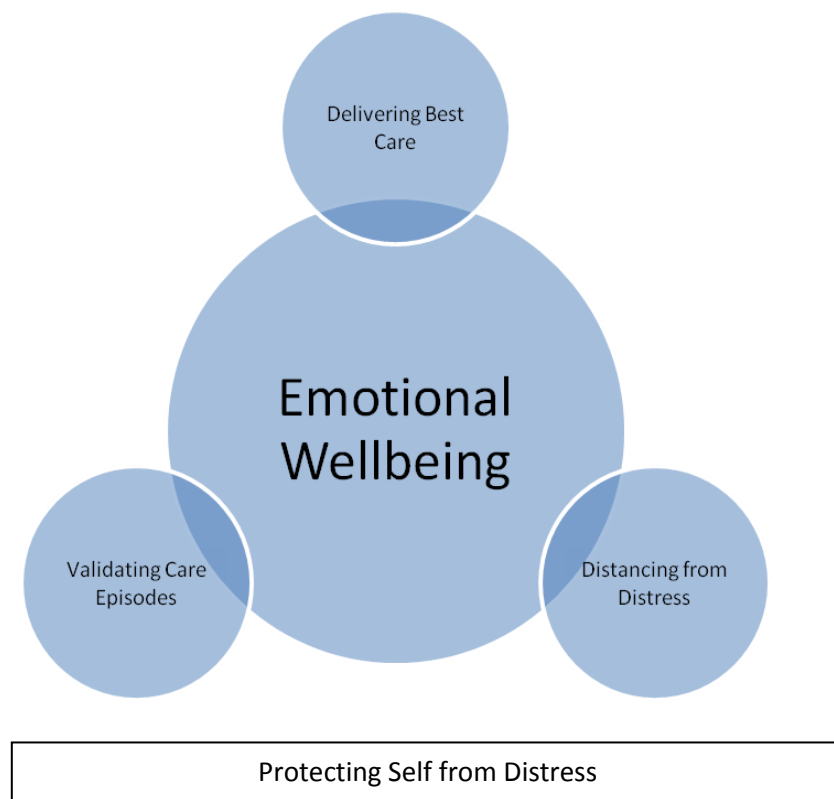
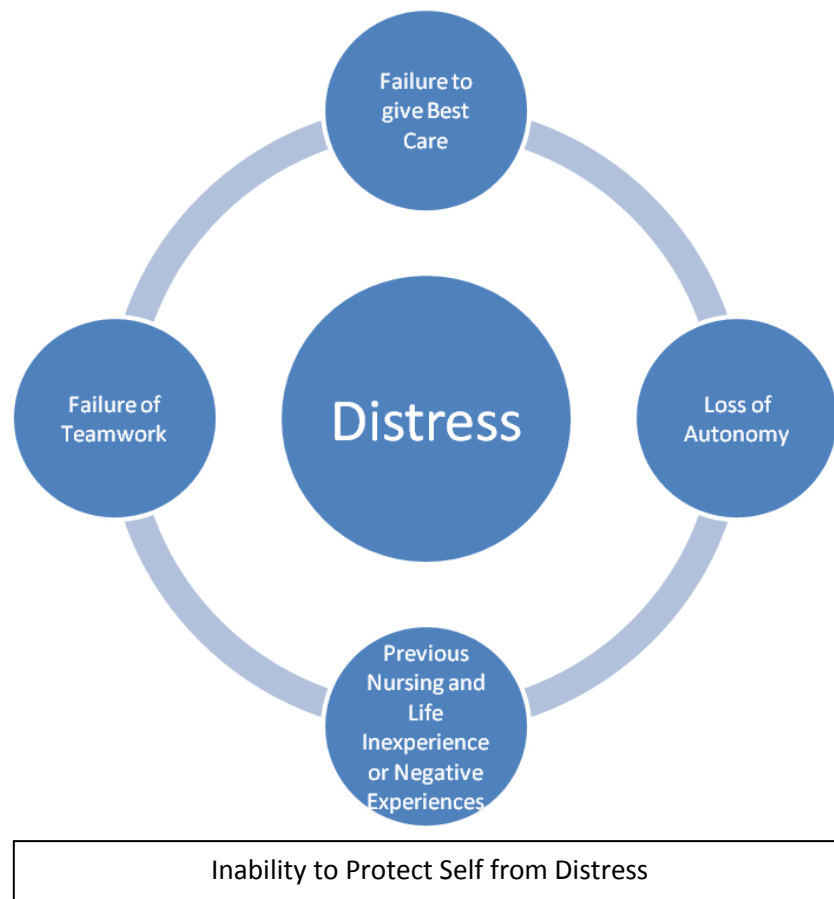


Figure 6.1 Emotional wellbeing of the experienced nurse in the Intensive Care Unit

6.2 The Context of Emotional Wellbeing

The investigation of nurse wellbeing in the ICU was identified in one other study (Le Blanc, de Jonge, de Rijk, & Schaufeli, 2001). Le Blanc and colleagues used detailed questionnaires to analyse work task categories against satisfaction, wellbeing and burnout. The authors of this quantitative study in a cohort of over 2000 European ICU nurses defined wellbeing in terms of job satisfaction and responses to questions about burnout in relation to a defined set of nursing tasks. Le Blanc et al.'s study demonstrated nurse satisfaction was derived from basic nursing tasks, however the conditions that were conducive to nurse wellbeing identified in this study were not investigated. The current study appears to be unique in its approach of exploring nurse wellbeing in the ICU through exploratory interviews and the development of a theory. The context of emotional wellbeing described in the present study was identified as nurse satisfaction, enjoyment and feelings of happiness. The contextual factor, nurse satisfaction, identified in this study has been investigated with different aspects of ICU nursing. For example, ICU nurse satisfaction with nursing care of patients and families (Bush & Barr, 1997), teamwork (Bach, Ploeg, & Black, 2009; Leon & Knapp, 2008; Söderström, Benzein, & Saveman, 2003), clinical decision making and autonomy (Bucknall & Thomas, 1996; Chaboyer, Najman, & Dunn, 2001; Landeweerd & Boumans, 1994) and work environments (Schmalenberg & Kramer, 2007, 2008) have been reported. However, none of these studies explored nurse emotional wellbeing in the detail presented in this current study.

6.3 The Core Problem of Nurse Distress

The core problem in this study was called *Inability to Protect Self from Distress* and comparisons with findings of other studies revealed similarities. Experiences and sources of distress have been widely investigated in the literature pertaining to stress and burnout in critical care nurses. The ICU is recognised as a stressful working environment due to the frequent exposure to pain, suffering and death (Hurst & Koplin-Baucum, 2005; Jezuit, 2000; Lindahl & Norberg, 2002). Research that has investigated stress in ICU nurses identified the most frequently reported stress varied and included staff shortages (Hays, All, Mannahan, Cuaderes, & Wallace, 2006; McVicar, 2003), confrontation with others (Jalowiec & Schaefer, 1993; Leino-Kilpi & Suominen, 1997; Robinson & Lewis, 1990) and fatigue, anxiety and frustration (Sawatzky, 1996). From literature at the time, McVicar (2003) collated evidence in relation to workplace stress and identified that ICU nurses ranked the emotional aspects of caring and frequent exposure to death and suffering as primary

sources of stress and distress (McVicar, 2003). Other studies have also identified the emotional impact of caring for patients and families as the primary source of distress for nurses (Hays, et al., 2006; Martins & Robazzi, 2009; Poncet, Toullic, Papazian, Kentish-Barnes, Timsit, Pochard, & et al., 2007). The experience of distress has also been reported as more difficult to manage when the patient or their family reminded them of situations or events within their own personal life (Kidd, 2009; O'Connell, 2008; Rushton, 1992).

Similar findings were also reported in a later qualitative study by Martins and Robazzi (2009) who investigated feelings of suffering in eight registered nurses who worked in a Spanish ICU. Most often reported as causing nurses to suffer were critically ill, young patients with the effect being felt by the whole team. Nurses had trouble detaching from the suffering of young patients even when they were away from the workplace. Nurses also suffered with long-term patients and those with whom they had formed a strong attachment (Martins & Robazzi, 2009). Whilst these sources of distress were also evident in the current study, examination of the data also revealed that nurses wanted to care for distressed patients and families and wanted to provide them with the best care.

Le Blanc and colleagues (2001) investigated ICU nurse wellbeing, and demonstrated that higher satisfaction was derived from physical and psychosocial nursing care despite this being the most demanding task category. However, there was a strong correlation between demand and emotional exhaustion, indicating the higher the nursing care demands, both physical and psychosocial, the higher the satisfaction, but also the risk of emotional exhaustion. The relationship between the level of emotional exhaustion and operational demands from caring for distressed patients and families supports the theoretical notion that feelings of exhaustion are associated with high interpersonal demands of relationships with patients (Maslach, 1982). The current study identified similar risk of emotional exhaustion but contributes further by describing the strategies nurses have employed to manage this. For example, balancing their exposure to distressed relatives with days off, holidays or being assigned less demanding patients on some days. Nurses also derived personal satisfaction from managing patients and their families, especially when they were in crisis.

Other sources of nurse distress have been investigated with studies designed to investigate phenomena such as ICU nurses experiences of grief (Spencer, 1994), death and dying (Bratcher, 2010; Brosche, 2003; Jezuit, 2003a), moral stress (Carvalho & Lunardi, 2009; Meltzer & Huckabay, 2004; Severinsson, 2003), treatment withdrawal (Halcomb, Daly, Jackson, & Davidson, 2004) and conflict (Coombs, 2003; Corley, 2002; McVicar, 2003). The current study investigated emotional wellbeing and from examination of the data,

identified all of these factors as having the potential to cause nurse distress. It also demonstrated that whilst nurses may experience distress, other factors influenced each situation within the ICU. The experience of nurse wellbeing or distress in responses to patients, families or the work environment was influenced by other circumstances or conditions.

6.4 Conditions that Impacted Emotional Wellbeing

In this study, conditions were identified that impacted on the nurses' emotional wellbeing and the nurses' ability to protect self from distress. Conditions could have either a positive or a negative impact. Five conditions emerged: best care, the relationship with the patient or family, autonomy, teamwork, and nurse experience.

6.4.1 Delivering best care

Nurse satisfaction was described in this study as derived predominantly from the delivery of best nursing care to patients and their families. The concept of best care in the ICU was identified from the interview data. Best care was determined by the nurse and achieving it was personally satisfying. This is in keeping with the experience of caring explored by Bush and Barr (1997) in a phenomenological study of 15 ICU nurses in the United States. The authors described ICU nurse caring as originating in the knowledge and feelings of the nurse. Caring was also a cycle of assessment, planning, implementing and achieving that resulted in feelings of personal satisfaction for the nurse.

Caring was central to the nurses' wellbeing in the present study and has been described as the core of nursing by others (Newman, Sime, & Corcoran-Perry, 1991; Watson, 1990; Watson & Smith, 2002). Caring is an emotional process and nurses respond by feeling rewarded for their effort. Experiencing satisfaction is enjoyable and motivates nurses to repeat the caring process.

The meaning of caring, for nurses, has been investigated in ICU and other nursing specialties and supports the findings of this study. The importance of the caring process and the delivery of satisfactory care were highlighted by Williams (1998) in an Australian Grounded Theory study. Set in specialty surgical wards of a tertiary metropolitan hospital, Williams identified that nurses determined the quality of nursing care by the degree to which the patient's psychosocial and physical needs were met. Termed, *therapeutic effectiveness*, quality nursing care was reported holistic and this was satisfying for nurses (Williams, 1998).

Consistent with others (Johns, 2001; Ryan, 2004), ICU nurses in this study also looked for visible evidence of caring and sought to enhance feelings of reward. Nurses focused on caring activities such as washing patients and positioning patients for comfort. Nurses stated that they liked to see the patient 'look' cared for and comfortable as it was a visible source of satisfaction. Families could also acknowledge nursing care when the patient looked clean and comfortable, validating the nurse's feelings of satisfaction. This study endorsed the findings of Wilkin and Slevin (2004) who investigated the meaning of care to ICU nurses. In a descriptive study using semi-structured interviews, the authors described ICU nursing as humanistic and 'that the capacity to care is affirmed and actualised in caring for the critically-ill patient and their relatives' (p50). This finding was demonstrated in the present study, where nurses drew satisfaction from determining what was best for the patient and family and achieving it.

In contrast, others have reported that ICU nurses had difficulty caring for patients because they focused on technology in ICU (Almerud, Alapack, Fridlund, & Ekebergh, 2008; Chesla, 1996; Wilkin & Slevin, 2004). In this study, nurses described managing technology and physiological parameters to optimise the patient's condition. Nurses derived satisfaction from optimising the patient's condition, but there was no evidence to support that technology distracted them from caring for the patient. The findings of the present study may be partially explained by Allix and Irurita (2004) who, in an Australian Grounded Theory study, investigated caring in a technological environment. Nurses demonstrated that they maximised interactions with patients in the presence of technology. This was achieved by focusing on humanistic aspects of caring. Even when attending to equipment in use with the patient, nurses exerted effort to interact with the patient, maintaining presence and individualising care interactions (Allix & Irurita, 2004). Allix and Irurita's study was undertaken in multiple nursing settings which included ICU and specifically focused on interactions with patients. In the present study, however, interactions with families were included by nurses when describing the care of patients. Nurses did not always make a distinction between patient and family and discussed family interchangeably with patients.

6.4.2 The relationship with the patient's family

The relationship with the patient's family was paramount to achieving best care in this study. Nurses liked to establish a rapport with family from the beginning and nurses articulated how they crafted the relationship to benefit the family, the patient and self. McCormack (2004) stated that the nature of the nurse-patient relationship was dependent

upon the context in which nursing care had taken place. It was apparent in this current study that nurses used the family to establish a relationship with the patient. Bouley, von Hofe and Blatt (1994) also found that ICU nurses established a trusting relationship with family. This was because the patient was unconscious and nurses needed to relate to the patient in some capacity. In addition, Bouley et al. stated that mutually trusting relationships with families set the scene to develop a trusting relationship with the patient once they were responsive. Developing a trusting relationship with families was also described as essential to building confidence and empowering families to regain control over difficult situations, a finding supported by others (Ryan, 1988; Söderström, Benzien, & Saveman, 2003; Stayt, 2007).

The importance of relationships with families in ICU has been investigated in many other studies. For example, despite finding working with families in ICU emotionally demanding, the majority of nurses in a Danish survey (97%, n=66) wanted to be involved in the psychosocial care of families (Agård & Maindal, 2009). Actions that helped or hindered the development of the nurse-family relationship were the subject of a Grounded Theory study, undertaken in the United States, by Hupcey (1998). Nurses described themselves as wanting to develop a positive relationship with families; an observation supported by families. Nurses also demonstrated commitment and perseverance in the relationship. Furthermore, in a second Grounded Theory study Hupcey (1999) identified that ultimately, both family and nurse worked towards integrating the family into ICU for the benefit of the patient. In addition, throughout the process, the nurse believed their role was to support families and help them through the experience. Nurses in this study described navigating families through the ICU experience, and finding positive ways to connect the family and patient, even in the direst of circumstances.

The focus and inclusion of family in caring for critically-ill patients is partly explained by the nature of critical illness. Families are usually frightened by the experience of ICU and in the case of unexpected illness or trauma, they can be in crisis. Families in ICU do need care and support. This study also demonstrated that nurses relied on the family to get to know the patient. Within the context of ICU, developing a relationship with the patient was facilitated by incorporating the family into the sphere of best nursing care. This may not be an exclusive phenomenon in ICU, but identified in this study because of the high nurse to patient ratio that has allowed nurses to develop relationships and incorporate family into their practice of delivering best nursing care.

Through the descriptions of best care, a similarity in the meaning and purpose emerged that may contribute to what is known about patient-centred care. Patient-centred

care is acknowledged as improving the quality of nursing care (O'Connell, 2008), which is an important aspect of best care in this study. Patient-centred care recognises the lived experience of illness as well as the scientific knowledge in health care. In 2001, Titchen identified two dimensions of patient care:

- The patient's responses, physical functioning and body typology
- The patient's feelings, perceptions, beliefs, imaginings, expectations, memories, attitudes, meanings, self-knowledge about and interpretations of health and illness, experience of illness and what is happening, response to illness, concerns and significant social relationships, life events and experiences (Titchen, 2001, p71).

This study demonstrates that ICU nurses sought to understand the patient's feelings, perceptions, beliefs etc., in relation to their illness from the perspective of the family. The inclusion of the family's feelings and responses into the definition of patient-centred care does not challenge Titchen's definition or mean that nurses in ICU are not practising patient-centred care. It adds the dimension to patient-centred care that nurses were fully aware of the relationships between patient and family. It recognises that the patient belongs to a social group, and nurses sought to understand and care for the patient within that dimension, through the family. Using their experience and knowledge, they show the family how to connect to their relative. The focus of best care is what is best for the patient and restoring the social relationships with their family in the context of critical illness.

The expressed belief that nurses cared for families was further demonstrated by the experiences of nurses when they could not establish caring relationships with aggressive patients and families. Nurses could not establish relationships with hostile patients or families and were unable to do their best. Nurses' explained that they were at other times frustrated in attempts to care because some families were not trusting or cooperative. Some families were just difficult to establish relationships with because they were perceived as demanding. Interacting with families of critically-ill patients has been identified as difficult and because they can be time-consuming and taxing for the nurse (Marco, Bermajillo, Garayalde, Sarrate, Margall, & Asain, 2006; Söderström, et al., 2003; Verhaeghe, Defloor, Van Zuuren, Duijnste, & Grypdonck, 2005). Nurses, in previous studies, have identified that they have experienced considerable distress, when relationships with families were not satisfactorily established (Holden, et al., 2002; Zaforteza, Gastaldo, de Pedro, Sánchez-Cuenca, & Lastra, 2005). The primary intention, identified by nurses in this study, when developing relationships with families was gaining trust and they believed that they did this well. Nurses have reported confidence in gaining

trust in other studies and used their experience to balance empathetic caring with professional conduct (Agård & Maindal, 2009; Söderström, et al., 2003).

Developing a good rapport with patients and family was important to achieving best care in this study. Nurses sought to establish trust and this failed when the patient or family were aggressive were inconsolably distressed. Nurses could experience frustration, fear and their own distress, all of which had a negative impact on wellbeing.

6.4.3 Autonomy

The condition *Autonomy* referred to the participants' descriptions of making clinical judgements and following through with appropriate care. Autonomy was part of best care and represented a highly-valued aspect of ICU nursing for those interviewed. There were frequent examples of nurses describing best care, setting goals and achieving them. In addition, nurses made clinical judgements for patients that were supported by medical colleagues. Nurses experienced satisfaction when working under these conditions and were confident of the care they delivered.

Similarities were found between the descriptions of autonomy in this study and what is already known in the literature. Autonomy is associated with the nurse's ability to make clinical decisions based upon professional knowledge and practices (Dwyer, Schwartz, & Fox, 1992; Wilkinson, 1997) and is regarded as desirable in professional practice (Ballou, 1998; Wilkinson, 1997). Several definitions exist within the literature (Ballou, 1998; Dwyer, et al., 1992; Wiens, 1990) but the one that encapsulated the meaning ascribed by the participants of this study states that: 'an autonomous nurse is one who practices within a self-regulating professional environment; makes decisions based on professional judgement, and is able to act on these decisions within his/her sphere of practice' (Wilkinson, 1997, p707).

In this study, nurses stated that they valued working autonomously because it enhanced work satisfaction and their own wellbeing. They also believed autonomy was supported in the study ICU environment. The relationship between autonomy within the workplace and satisfaction is well-known and it forms the underpinnings of occupational psychology (Landeweerd & Boumans, 1994; Laschinger, Finegan, Shamian, & Wilk, 2001; Tummers, van Merode, & Landeweerd, 2002). Nurses in the current study stated that they were attracted to work in conditions that allowed practice-autonomy, good relationships with colleagues, high quality care and strong nursing leadership that valued its employees, all of which is strongly supported in the literature (Armstrong, 2005; Choi, et al., 2004; Landeweerd & Boumans, 1994; Laschinger, et al., 2001). Environments supportive of

autonomous practice have been reported as being associated with a better health status among nursing staff (Armstrong, 2005; Budge, Carryer, & Wood, 2003; Kramer & Schmalenberg, 2008).

Nurses in this study believed that they had advanced their own professional practice skills working in the ICU. They also believed that autonomy was greater in the ICU when compared to their own experiences of nursing outside of the ICU. The scope of nursing practice and perceived autonomy valued by this group of nurses most likely developed because of the nature of critical illness. Carnevali (1984) argued that working in an environment of life-threatening situations demanded that ICU nurses must become competent to diagnose and respond in the medical domain and be an expert clinician. The ICU nurse has been described as seeking challenge, attracted to working within a complex, technology-rich environment (Hays, et al., 2006; Hurst & Koplin-Baucum, 2005; Tsay, et al., 2001). The findings of these studies were observed in the current study from descriptions of nurses wanting to care for complex patients because they were challenging. Nurses also stated that they were experienced at caring for complex ICU patients and became frustrated if they had several shifts in a row without being allocated a critically-ill patient. Satisfaction and wellbeing was derived by working to their capacity.

Regardless of the degree of autonomy allowed, the scope of nursing practice must be observed and conflict with doctors over clinical decision-making had a negative impact on nurse wellbeing in this study. Nurses mostly described their medical colleagues as being supportive of nurses' clinical decision-making, which has also been reported by others (Baggs Schmitt, Mushlin, Eldridge, Oakes, & Hutson, 1997; Budge, et al., 2003; Coombs, 2003). In this study and others, conflict with medical colleagues has been described as frustrating and at times caused distress for nurses (Coombs, 2003; Corley, 2002; Halcomb, et al., 2004). In concordance with Cartledge (2001), the nurses interviewed in the current study identified conflict with doctors as a considerable source of distress. Conflict with junior medical staff over routine clinical decisions caused nurses to feel frustrated and angry.

Power and conflict in intensive-care clinical decision-making was investigated in an ethnographic study across three ICUs in the UK (Coombs, 2003). Positive working relationships between doctors and nurses were observed, however, conflict with clinical decision-making was evident. Nurses were reported as feeling that they did not fully participate in clinical decision-making and that doctors held a power base that controlled this (Coombs, 2003). In the current study, conflict over clinical decisions that caused nurses the most distress occurred when caring for patients that were deemed medically futile. This

was described as being when caring for patients with active medical treatment that nurses believed was prolonging death. Nurses believed that they were excluded from having meaningful impact on the decision-making process. Furthermore, nurses were then required to continue treatments they believed were prolonging suffering. Nurses experienced emotional conflict caring for some patients because they believed they were contributing to suffering.

Nurses have previously commented on the rates of mortality and the manner in which the 'hopelessly ill' were managed in ICU (Cartledge, 2001; Hov, Hedelin, & Athlin, 2007). The distress experienced with medical futility was described by Rushton (1992) as creating moral conflict. Opposing moral responsibilities have been described as competing tensions between promoting a peaceful death and prolonging life at all costs (Carvalho & Lunardi, 2009; Rushton, 1992). The moral dilemma experienced by ICU nurses was finding the balance between the objective (managing the technological side) and subjective (individualised, humane caring) sides of caring (Wilkin & Slevin, 2004). The proliferation of technology makes possible the prolongation of life that in some circumstances prolongs death (Almerud, et al., 2008; Beeby, 2000; Johns, 2005; Wilkin & Slevin, 2004). Failure to achieve goals and feelings of powerlessness occurred most frequently in the current study when nurses were involved in patient care that they believed was medically futile. Caring for patients who were hopelessly ill was distressing for nurses.

Medical futility has been defined as providing inappropriate treatments that will not improve disease prognosis, alleviate physiological symptoms, or prolong survival (Mohammed & Peter, 2009). Frick, Uehlinger, and Zenklusen (2003) found that there was disagreement amongst doctors and nurses with respect to their judgement on the futility of medical interventions with ICU patients. Although doctors were not included in the present study, nurses echoed this sentiment. Interestingly, Frick et al., also found that nurses were generally more pessimistic in the 1,932 daily judgements recorded on 521 patients, they were more often correct in asserting that a patient was dying. However, nurses more often proposed treatment withdrawal with patients who subsequently survived. It was concluded that neither doctors' nor nurse's predictions on survival from ICU, or quality of life at six months following ICU discharge, were reliable (Frick, et al., 2003). These findings can be related to the present study in that clearly for some patients, clinical decision-making is challenging and predicting survival continues to be a contentious issue between doctors and nurses. Findings from this study and those discussed indicate that communication between doctors and nurses needs to be more collaborative. Nurses need to be able to vocalise their observations of patient, relatives and their own distress in these situations.

6.4.4 Teamwork

Another condition identified from the data that could impact either negatively or positively on emotional wellbeing was called *teamwork*. Teamwork referred to working in cooperation with nursing, medical, allied health and ancillary staff. Nurses used the multidisciplinary team to achieve patient-centred goals and to develop collegial relationships that were supportive. The working relationships described within the team were social as well as professional. Nurses described teamwork as creating an atmosphere of mutual support that included watching out for each other to lend a hand or give somebody a break if they needed some time out. The participants identified positive elements such as communication, support and friendship as beneficial to their wellbeing. Working within the team in this study enhanced feelings of satisfaction and it provided a social structure that was supportive and fun. In contrast, nurses who did not feel supported in the team experienced isolation and distress. At its extreme, nurses who were denied or unable to connect to functional, supportive and social relationships within the team left ICU. Whilst only one example of a nurse leaving was presented in this data, experiences of disgruntlement and isolation were demonstrated when nurses in this study did not feel supported by the team.

Communication was identified in this study as crucial to teamwork. It encompassed involvement with clinical decisions, collaboration with care and opportunities to just chat with colleagues. In contrast, nurses experienced frustration and dissatisfaction when teamwork was absent. Nurses felt that teamwork failed either when they were excluded from clinical decision-making or were unsupported by colleagues when caring for patients. Collaborative teamwork was investigated by (Reader, Flin, Mearns, & Cuthbertson, 2009) in a literature review aimed at developing a team performance framework for the ICU. Units that reported high levels of collaboration between nurses and doctors also reported higher levels of nurses and junior medical staff satisfaction. High levels of collaboration were also associated with improved end-of-life care (Reader, et al., 2009). Martins and Robazzi (2009) established that nurses experienced both suffering and anxiety when caring for patients and were not part of the clinical decision-making process. This present study contributes to the argument that nurses need to be more actively involved in clinical decisions as part of a team approach to determining the best approach to patient management.

Structural elements such as the open plan of ICU, the experience of staff and managerial support were identified in this study as important for teamwork. These structures have been described as supporting care processes, relationships and

communication that are fundamental to teamwork (Atwal & Caldwell, 2006; Dixon, 2008; Pilcher, 2009; Schmalenberg & Kramer, 2007). The American Association of Critical Care Nurses developed the Nursing Worklife Model which includes five major elements to support nurses (Manojlovich & Laschinger, 2008). These include: nurse manager ability; leadership and support; staff nurse participation in hospital affairs; collegial nurse-physician relations; and staffing and resource adequacy. The Worklife Model recognised the importance of a healthy ICU working environment which included: skilled communication; true collaboration; effective decision-making; appropriate staffing; meaningful recognition; and authentic leadership. Support from managers and collegial relationships within the multidisciplinary team were identified as essential elements to the teamwork environment in the present study.

Nurses interviewed in the current study expressed an expectation that all nurses worked within the teamwork ethic and contributed to creating a supportive environment. Mostly, teamwork was described as effective and that the philosophy within their work environment was cultural, driven by strong leadership from both senior nurses and senior doctors. Communication was essential to teamwork, and the ability to work within the team was something that nurses encouraged in junior nursing and medical staff. A teamwork environment provided support and social relationships that nurses used for debriefing and reflection. This aspect of teamwork will be discussed under the process nurses used to maintain wellbeing.

6.4.5 Previous nursing and life experience

Previous nursing and life experience was also identified as a condition that could have a positive or negative impact on the emotional wellbeing. Nurse experience underpinned the development of nurse autonomy and the collaborative skills essential to teamwork. Nurses also derived knowledge through experience and were confident of their nursing skills managing the physiological and emotional demands of the critically-ill patient/family. For some nurses however, experience was at times felt to be a burden. For example, in situations when nurses were allocated difficult patients or distressed families over consecutive work shifts, or when nurses became exhausted, with some nurses stating that they felt like taking sick leave.

In this study, experience was essential to the ability of the nurse to develop practice autonomy and to develop the collaborative skills essential to teamwork. Most importantly to those interviewed, experience was reported as enabling nurses to make clinical decisions for the patient. Within the ICU, experience has been identified as an important variable

within the decision-making process (Bucknall, 2000). In an observational study, nurses with more than five years experience were more active in communicating decisions to others (Bucknall, 2000), particularly other health professionals, in a collaborative manner to improve the patient's clinical condition. Junior nursing staff were less likely to communicate clinical problems or implement a treatment, until they were certain the condition required treatment and were more likely to then defer decisions to someone more senior (Bucknall, 2000). Clinical decision-making is arguably different in the ICU given the nature of critical illness, demanding intensive care of both patient and family (Bucknall & Thomas, 1995). Nurses in this study believed they used their experience in clinical decisions and communication with the team. Experienced nurses in this study enjoyed working in ICU, they did not find it stressful.

Experience in other studies has also been demonstrated to reduce perceived stress from working in the ICU. For example, Burgess and Wallymahmed (2010) surveyed a convenience sample of 46 ICU nurses and demonstrated that the greater the years of experience, the lower the level of perceived stress. The Burgess and Wallymahmed study demonstrated a negative correlation between number of years nursing and stress from home-work conflict ($p=0.03$), and dealing with patients and relatives ($p=0.02$). The authors believe that this finding was related to the level of autonomy fostered in this group of nurses, a construct already discussed in this study. Other studies have linked the effect of experience on confidence and empowerment (Stichler, 2009; Suominen, Leino-Kilpi, Merja, Doran, & Puukka, 2001; Varjus, Suominen, & Leino-Kilpi, 2003). In particular, it has been reported that ICU nurses possessed self-confidence in skills and competencies and that job autonomy increased with age and experience (Suominen, et al., 2001). These findings are important because the present study and others (Beeby, 2000; Schmalenberg & Kramer, 2007; Storesund & McMurray, 2009) demonstrate that all of these factors impact the ability of the nurse to deliver best care. Best care, as demonstrated earlier, is important to nurse wellbeing.

In comparison, there were some incidents in the data where nurses felt that their experience exposed them more frequently to distress. For example, nurses wanted to care for complex and difficult patients because they were challenging. However, sometimes, complex or patients with distressed families were allocated to the same nurse too often, because they were the most experienced. At these times, nurses became exhausted, particularly if they cared for several patients who died within a short time period. This finding supports those of Le Blanc and colleagues (2001) who investigated the wellbeing of almost 2000 ICU nurses representing 13 European countries. They demonstrated that the

higher the nursing care demands, both physical and psychosocial, the higher the satisfaction but also, the risk of emotional exhaustion (Le Blanc, de Jonge, de Rijk, & Schaufeli, 2001). Emotional exhaustion has been reported as a contributor to 'burnout' and the desire of nurses to leave ICU (Meltzer & Huckabay, 2004; Mobley, Rady, Verheijde, Patel, & Larson, 2007; Poncet, et al., 2007). In contrast, there were times where nurses felt they were given 'easy' patients and became frustrated because they felt their skills were not utilised. Nurses sought balance in their work, they wanted to feel useful and challenged.

Being an experienced ICU nurse practitioner for nurses in this study was mostly perceived as a positive attribute. Nurses had become experts in their field and were competent caring for patients in ICU. There were occasions when experienced nurses felt vulnerable and they were at risk of periods of exhaustion or boredom. Experience was also important in the development of nurse teamwork, autonomy and clinical decision-making. Overall, experienced ICU nurses sought balance at work and finding balance is a strategy that is discussed in the next section, *Protecting Self from Distress*.

Nurses described strategies that they had developed through experience which enabled them to deliver best care to patients and this was how nurses maintained their emotional wellbeing working in the ICU. Strategies to deliver best care were aimed at overcoming threats that came from relationships with patients and families, loss of autonomy, lack of teamwork and negative aspects of nurse experience. The strategies that nurses used is discussed in the next section *Protecting Self from Distress*.

6.5 Protecting Self from Distress

The process ICU nurses used to maintain their emotional wellbeing included strategies to overcome threats to their ability to deliver best care. Threats included difficult relationships with families, loss of autonomy, failure of teamwork and their own personal experience. This study developed a substantive theory that describes the process nurses used to overcome the threats to their wellbeing in three phases. The first phase represented *Delivering best care*, which was discussed in the previous section. This section focuses on the remaining two phases, *Validating care episodes* and *Distancing self from distress* that were described in the process *Protecting Self from Distress*. These include the strategies used to overcome threats to autonomy, teamwork, nurse experience and relationships with patients and families.

6.5.1 Validating care episodes

Working in close proximity with each other provided opportunities to develop relationships and find time to talk. Nurses used the opportunity of working closely to talk about the challenging and emotionally difficult aspects of ICU nursing, and to validate feelings of satisfaction. Nurses stated that they actively take part in reflection and debriefing, an informal process of interactions with colleagues to share thoughts and feelings. Nurses used these interactions to overcome distress, accept the outcomes for patients and keep themselves grounded as individuals.

Debriefing and reflection, and problem-focused and emotion-regulating behaviours have been described as seeking social support to adapt and normalise stressors (Cosway, Endler, Sadler, & Deary, 2000; Endler & Parker, 1990; Folkman & Lazarus, 1988). In their seminal work, Folkman and Lazarus (1988) explained that emotions depend upon cognitive appraisals of the person-environment relationship to determine the significance to self and wellbeing. In this study, nurses sought social support from colleagues to appraise the relationship between self, the ICU environment and their own emotional responses. Talking to colleagues is beneficial because they share the same experiences within the ICU environment. Nurses in this study frequently commented that they chose to debrief and/or reflect with their colleagues about events at work, stating that often friends or family would not understand their experience. Being able to talk to colleagues, who share the same experiences, gives meaning to difficult situations and helps nurses in the coping process.

Whilst some studies have identified formal debriefing as a way of minimising the impact of critical incident stress (Caine & Ter-Bagdasarian, 2003; Cotterill-Walker, 2000; Lenart, Bauer, Brighton, Johnson, & Stringer, 1998), there are very few that report on informal debriefing. This study demonstrated the importance of working relationships with colleagues and that nurses valued and nurture the team environment. The ICU environment fosters friendships that enable nurses to debrief and reflect on their work. Martins and Robazzi highlighted the value of interpersonal relationships with colleagues in a qualitative investigation of ICU nurses and the impact of exposure to suffering. Nurses reported that they established friendships and trust with colleagues to relieve tension and participate in mutual support. Nurses sought opportunities to share experiences and knowledge and discussed creating moments to unwind with colleagues. Similarly, Shorter and Stay (2010) observed that nurses sought their colleagues for support and that informal opportunities to reflect and debrief were effective coping strategies. They also found that nurses preferred to seek support from colleagues in ICU more than formal counselling

which was rarely used (Shorter & Stayt, 2010). In the present study, participants stated that formal counselling sessions were rarely helpful with nurses preferring to talk amongst themselves.

The ability to reflect and debrief with colleagues working closely together enables nurses to validate their care and continue delivering best care. Sharing frustrations and emotions alleviates distress and nurses were able to get on with the business of achieving best care. Achieving best care, particularly when dealing with emotionally distressed families, helps to restore nurse wellbeing and has been identified as vital to caring in ICU (Beeby, 2000). Storesund and McMurray (2009) reported that support and teamwork were crucial factors that influenced the perceptions of quality care in the ICU. Data from semi-structured interviews with ten nurses, demonstrated that support included debriefing and socialising with colleagues. Nurses in the current study relied on the team for support, morale and to assist them in the delivery of best care. A collective team consciousness that determined team rules was implied by the common descriptions and expectations of team function. This became more apparent in the expressed disappointment when colleagues had not been seen as supportive or helpful to each other. A cohesive team has been demonstrated as providing support and, as a consequence, positive team morale is believed to elicit an improvement in the quality of care to patients (Storesund & McMurray, 2009). Storesund and McMurray identified that sharing knowledge and experiences with colleagues was an essential part of nurses delivering best care and, common to the present study, also identified that teamwork was a vital component in socialising new staff assisting in creating strong group cohesiveness, essential to supporting nurses (Storesund & McMurray, 2009). Storesund and McMurray (2009) concluded that 'caring for another human being is the core of nursing, it is essential for nurses to understand how their actions and perceptions affect high quality care' (p125). In addition, satisfaction derived from the delivery of high quality care is what may keep nurses nursing.

Nurses in the current study demonstrated that they derived satisfaction from caring for patients and their families. The delivery of best care was dependent on conditions such as teamwork and support from colleagues. This current study and others indicate that social support from colleagues facilitates debriefing that is vital in overcoming emotional responses such as distress, grief, frustration and critical incident stress (Badger, 2005; Cotterill-Walker, 2000; Lenart, et al., 1998; Spencer, 1994). Debriefing in this study also led to nurses being able to reflect and find psychological acceptance of patient and family distress. Acceptance meant that nurses were able to experience thoughts and feelings associated with the patient and not experience distress themselves. Acceptance of work

stressors has been linked to increased job control, satisfaction and higher work performance (Bond & Bunce, 2003). Importantly, Martins and Robazzi determined that feelings of suffering reflected the reality of the situation and nurses accepted the feelings of suffering experiences at work as inherent in their profession (Jezuit, 2003; Martins & Robazzi, 2009).

The intensive care unit where this study was undertaken does not have formal debriefing sessions as such, but some of what was described by the nurses in this study also exists in the literature describing clinical supervision. Clinical supervision is a formal process of group reflection with peers used to develop professionalism and increase quality care (Severinsson & Kamaker, 1999). Lindahl (2002) investigated clinical supervision in the ICU as a space for relief, sharing emotions and experiences of care. Nurses used these sessions to reflect on unit morale and recognition of the need to support each other. Nurses in this study found this helpful and one advantage of clinical supervision over informal debriefing and reflection is that it includes all nurses. Nurses in the present study all found informal opportunities to debrief and reflect with colleagues. Those interviewed were all experienced and had time to develop friendships that facilitated this. There may be other staff that do not experience the same level of support, for example junior staff.

Nurses identified the importance of their social and professional relationships with colleagues which they believed were fostered within a teamwork environment. The ability to debrief with colleagues was essential to maintaining wellbeing. Nurses believed that sharing the same or similar experiences enhanced the capacity to understand and support each other. Reflecting on care also helped nurses to understand and accept the outcomes for patients and families. Reflection and debriefing activities that participants in this study believed were good for emotional wellbeing and helped nurses continue caring for patients in the ICU.

6.5.2 Distancing self from distress

The process which nurses used to protect themselves from distress also includes strategies that create a physical, psychological or emotional barrier between the nurse and potentially negative experiences. Nurses create distance to protect themselves from distress and enable themselves to continue working in the ICU. Creating a physical distance sometimes means avoiding caring for certain types of patients because nurses anticipate difficulty managing their own emotional responses. At other times, nurses remove themselves from the patient in the form of extra or long tea breaks, and planning breaks such as holidays. Other types of distancing used by nurses includes creating an emotional barrier or using

distraction such as humour, purposely thinking about something positive/enjoyable or just chatting to colleagues.

The purpose of strategies such as distraction, humour and just chatting is to protect nurses from the emotional distress of patients and their families. Nurses acknowledged that managing families in crisis is part of their job and they can usually manage their own patient/family if distressed. However, the close proximity of nurses to other patients/families within the open plan makes it hard to not feel involved with the distress of others. It is not surprising that this group of nurses have developed coping strategies that distract them from what is going on at an emotional level and enables them to do their job. This finding is similar to the concepts of stress and coping defined by Lazarus and Folkman (1984). That is, the function of distancing for this group of nurses is to tolerate, minimise, accept or ignore the demands of frequent exposure to emotional distress within the ICU, without attempting to master it.

The most frequently reported coping strategies for ICU nurses include planful problem solving and seeking social support (Becker-Carus, Gunthner, & Hannich, 1989; Lenart, et al., 1998; Martins & Robazzi, 2009; Shorter & Stayt, 2010; Spencer, 1994). In one study, Hays et al., (2006) reported that 59.2% (n=80) of nurses used planful problem solving and 49.5% (n=68) seeking social support 'quite a bit'. Whereas the majority of nurses reported that they only used escape avoidance (62.2 %, n=84) and distancing (54%, n=73) 'sometimes'. In this current study, seeking social support was reported.

From the findings of the current study, chatting, humour and distraction were perceived to have positive outcomes for emotional wellbeing of this group of nurses. Nurses also reported that they avoided some patients to protect their emotional wellbeing. Examining the use of avoidance with what is already known suggests that in the long term, this may be problematic (Iglesias, Vallejo, & Fuentes, 2010; Poncet, et al., 2007). Certainly in this study, when nurses were exposed too often to patients they found distressing, they reported exhaustion and at its extreme a desire to leave.

Avoidance behaviours are generally described as maladaptive in contrast to strategies that seek to manage the problem at hand and govern the emotional responses (Cosway, et al., 2000; Endler & Parker, 1990; Folkman & Lazarus, 1988). Iglesias and colleagues (2010) investigated Experiential Avoidance in a group of 80 Spanish ICU nurses. Experiential Avoidance is a response to unwanted thoughts, feelings or sensations that a person uses conscious and purposeful tactics to avoid, and can result in impaired functions or interactions (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). Iglesias et al., (2010) identified a positive correlation between experiential avoidance and three subscales of

burnout syndrome, emotional exhaustion ($p=0.01$), personal accomplishment ($p=0.05$) and depersonalisation ($p=0.01$). This is relevant to the current study because there are examples of nurses wanting to leave if they could not manage their exposure to distress or find enough social support at work to manage their own feelings.

Also of importance are findings from another study where nurses, who were older and more experienced, reported higher scores of emotional exhaustion (Ehrenfeld & Bar-Tal, 1995). Although unlike the present study, Ehrenfeld also reported that older nurses used fewer coping strategies than their younger counterparts. Other studies have reported a positive correlation between moral distress, emotional exhaustion and feelings of burnout and a desire to leave ICU nursing (Meltzer & Huckabay, 2004; Poncet, et al., 2007). In this study, nurses most often describe trying to avoid medically-futile patients because they felt that the patients and families were suffering and this was distressing. Badger (2005) investigated moral discord, feelings of operating against one's own beliefs, using observations and focus groups with 24 ICU nurses. Moral discord occurred when contextual factors prevented nurses from acting upon their own moral mandate and were unable to do what they believed was best for the patient. Badger grouped the coping strategies used to manage moral distress when confronted with an ethical conflict associated with patient care. Coping strategies included keeping busy to avoid thinking about the situation, actively engaging families to facilitate treatment decisions, and seeking medical staff to discuss termination of treatment. Emotional responses included avoidance and requesting not to care for certain patients as a way of distancing themselves. Many of the elements described as coping strategies were identified in the current study, in the process used by nurses to maintain their wellbeing.

In this study, distancing strategies such as distraction, chatting and the use of humour are activities that help nurses maintain their wellbeing. Nurses also stated that they avoided certain patients to protect their wellbeing. Avoiding patients or experiences was accepted practice in this study and supported by the team. Whilst avoidance is a sign of exhaustion, it is also necessary for nurses to recognise when they are exhausted and protect themselves. Selecting not to care for some patients, sometimes, allowed nurses to protect their emotional wellbeing and continue working in the ICU. This study indicated that it was more important for nurses to monitor the number of times they choose to avoid patients, as this may be more indicative to the type of exhaustion and whether or not they are suffering from burnout (Bond & Bunce, 2003). Nurses in ICU seek to find balance, with distancing themselves from some experiences being a protective mechanism that is good for wellbeing.

6.5.3 Self-care

Nurses in ICU understood the need to care for themselves and could identify the types of activities that they participated in to maintain their own wellbeing. Strategies such as creating a psychological barrier between themselves were achieved by listening to music on the way home. Some nurses used symbolic gestures such as removing their 'work' coat as they entered their home or showered to re-enter the home environment. Nurses psychologically left their work experiences aside and entered their home unburdened. They also made the most of their time away from work and engaged in activities such as exercise, meditation, massage and spending time with their families. Some nurses also used substances such as alcohol, 'having a glass of wine' to unwind. At times, when nurses experienced emotional distress, they sought comfort from their own families, expressing that once they shared the negative experiences they could resolve it. Taking regular holiday breaks was also a strategy to protect nurses from becoming overwhelmed with distress.

Strategies used by ICU nurses away from work to maintain emotional wellbeing at work were not identified in the current literature. Instead, studies focused on coping strategies that ICU nurses used at work (Burgess, Irvine, & Wallymahmed, 2010; Hays, et al., 2006), exercises, activities and hobbies outside of work have all been identified as measures that ICU nurses used to relieve stress and distress (Martins & Robazzi, 2009; Robinson & Lewis, 1990; Spencer, 1994). Robinson and Lewis surveyed 577 ICU nurses from 23 ICUs in the United States. Three of the top ten coping strategies identified as usually or always used included watching television/reading (46.4%), exercise (26.5%) and taking holidays (24.6%). Alcohol was reported as usually or always used as a coping mechanism by 2.9% of those surveyed (Robinson & Lewis, 1990).

One finding that did vary from recent literature was the reliance on the nurse's own family and friends for comfort at times of emotional distress. Badger (2005) reported that nurses usually chose to seek social support from their colleagues. Whilst the current study found this also to be true, it identified that when nurses were distressed, they also sought comfort from their own family as well. This finding was reported in a much older study by Spencer (1994), who investigated ICU nurses responses to feelings of grief experienced whilst working in the ICU. From a survey of 72 nurses, Spencer reported that 27.5% of nurses indicated that that they talked to their own friends when they experienced grief at work. Nurses seeking comfort from their own family and friends following experiences of distress in ICU was not identified in other studies for this group of nurses.

It is important to recognise the benefits of self-care when working in emotionally-distressing environments. Self-caring activities undertaken away from the workplace such as relaxation or exercise could be promoted by nurse managers or educators to all nurses. It is also important to recognise that experienced practitioners have demonstrated that they took responsibility for their own self-care. They sought to care for themselves because they wanted to do their best at work and this meant maintaining their own wellbeing.

6.6 Conclusions

This study was undertaken in an ICU located in Perth, Western Australia. In this ICU, the patient to nurse ratio is at least 1:1, with 24-hour support of the multidisciplinary team within the unit. This environment provided the opportunity for nurses to achieve best care of both patient and family. Best care for patients and their families was patient-centred, with the family providing an emotional context to the patient that was not otherwise available to the nurse. Nurses enjoyed working in ICU because they felt satisfied with the care they gave. This study presented examples of where nurses achieved episodes of care that made them feel so satisfied that it motivated them to want to remain working in ICU. Maintaining the nurse to patient ratio is vital to facilitate holistic, patient-centred care and therefore nurse wellbeing in ICU. This finding may also have relevance to other nursing work environments such as ward areas. Providing ward nurses with the resources to ensure that all nurses are satisfied with the care they give could be an important retention strategy.

Current literature investigating the emotional impact of working in ICU has focused on identifying stressors and ways of coping. This study takes a unique approach, investigating experienced ICU nurses to determine how they maintain their emotional wellbeing in the ICU. This study demonstrates that ICU nurses were determined to give best care to patients and their families and this was how they maintained their emotional wellbeing. Threats to the delivery of best care and the strategies nurses used to overcome threats were also identified. This study concludes that minimising threats to the delivery of best care will promote satisfaction of nurses and may contribute to higher retention rates. The satisfaction and happiness enjoyed by nurses was found to be the reason the group in this study remained nursing in ICU.

The most distressing experiences described by nurses in this study involved decisions around end-of-life care in ICU where treatments were seen to prolong life and suffering. Conflict with junior medical staff and lack of autonomy were also highlighted as major contributors to frustration, dissatisfaction and distress for nurses.

This study also demonstrated that ICU nurses wanted support from their colleagues in the form of informal debriefings, group reflection for professional, emotional and social support. Nurses sought to strengthen interdisciplinary relationships through supportive teamwork practices and mentored beginner ICU nurses to adopt similar group behaviours. Nurses also valued teamwork to support nurse autonomy and practised using advanced clinical and critical thinking skills. The separation between home and work life and finding the right balance was also important to this group of nurses.

6.7 Limitations

This study was undertaken with a small group of experienced Australian ICU nurses in one clinical setting. There may be processes and strategies used by less experienced nurses, or by nurses of different cultural backgrounds, that have not been identified. This study did not investigate nurses who have worked in ICU and subsequently left, and there may be experiences that were detrimental to nurse wellbeing that have not been identified in this study. The data source was restricted to interviews only and may have been strengthened with the addition of other sources such as observations, or interviews with management or senior medical staff.

A substantive theory was developed in this study explaining how experienced ICU nurses maintain their emotional wellbeing. It is acknowledged that this theory is limited in its complexity by the restrictions of time allocated to a Master's Thesis.

6.8 Recommendations

A number of recommendations concerning nurses and their emotional wellbeing can be made from this study. The process nurses used to maintain their wellbeing has included most notably, the relationship between the delivery of best care and nurse's satisfaction. Supporting nurses to do their best, which includes recognising factors such as nurse autonomy and teamwork may provide strategies for nurse retention. From the perspective of ICU management, nursing education and research, insights from this study may be useful.

Specific recommendations for ICU management:

- That managers and organisations recognise the relationship between nurses, work place satisfaction and emotional wellbeing. Practices such as self-rostering and input into patient assignment so that nurses control their exposure to emotionally difficult situations.

- That ICU's review policy and practice in regards to decisions around end-of-life care in ICU and develop strategies whereby opportunity is provided for nurses to be involved in decisions.
- That ICU's encourage nurse autonomy through policy and guidelines that recognise scope of ICU nursing practice.

Specific recommendations for Nursing Education:

- That opportunities for the use of informal debriefing and reflection with colleagues be provided within the ICU setting.
- That positive behaviours and attitudes of team members such as communication, respect and support, be fostered and promoted within the ICU team.
- That opportunities for ongoing education and maintaining skills are provided for all nursing staff.
- That managers provide equal opportunities for education to all staff, regardless of the number of hours they are employed or type of shift work.
- That education support and mentoring is available to all nursing staff.
- That nurse education includes promotion of self-caring activities such as exercise, meditation and other relaxation techniques to promote wellbeing.

Recommendations for further research:

- That further quantitative evaluation/exploration of the degree to which factors/conditions impact on nurse wellbeing is undertaken and tools that can measure these are developed.
- That the effectiveness of different models of debriefing and reflection for ICU nurses is explored.
- That nurse wellbeing is explored in other work settings.
- That an instrument is developed to assess the degree to which a particular ICU work environment promotes emotional wellbeing that can be used for benchmarking and improving work conditions that support wellbeing.
- That the possible relationship between satisfaction with the delivery of nursing care in ICU and emotional wellbeing is explored further.

This study has highlighted the importance of identifying and supporting the conditions conducive to the delivery of best care. There is a long standing worldwide shortage of nurses in conjunction with an aging workforce. Despite this, many nurses enjoy nursing and the personal satisfaction from their unique role in the healthcare system. Supporting nurses

to deliver best nursing care to patients and families in the ICU will be strategically important for the nursing workforce, nurse retention and patients.

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APPENDIX A

PARTICIPANT INFORMATION

Study Title: Maintaining Emotional Wellbeing in the Intensive Care Unit: A Grounded Theory Study from the Perspective of Experienced Nurses

Investigators: Ms Joanne Siffleet, Dr Anne Williams and Dr Pat Rapley

Dear Colleague,

As part of the fulfilment for a Masters in Nursing by Research at Curtin University of Technology, Perth, I will be conducting the above study over the next 12 months in ICU at SCGH. The study is a qualitative investigation, exploring the emotional wellbeing of critical care nurses, who are working in ICU. Nurses working in critical care areas such as intensive care work in a technically complex and dynamic environment and are exposed to multiple workplace stressors.

This research will explore the experience of nurses working in the Intensive Care Unit (ICU) in relation to emotional wellbeing and the strategies used to manage working in the ICU environment. This research will be used to construct a theoretical model that describes how nurses respond to the ICU environment and how they engage in maintaining their own emotional wellbeing.

Participation in this study will involve individual interviews of approximately 1–1.5 hours duration with the researcher. The interview process will be in the format of an informal discussion and can be stopped and/or continued at your discretion. The hospital's counseling services are freely available to you if you would like to discuss any issues further that result from the interview. The interviews will be recorded by audio-tape and later, transcribed. Demographic information will also be collected at that time. The researcher may seek clarification from you some time following your interview. If you would like to know more about this study and think that you would like to participate, please contact me (details below). Participation in this study is voluntary and if you do not wish to participate, your refusal will be accepted without question.

Data from this study will be collated, analysed and reported in the format of a thesis for assessment. It is also intended that the findings from this study may be submitted for publication in a reputable nursing journal and/or presented at conferences. All participants will be given a code for identification to protect confidentiality within the study. As this is a small study, demographic data will not be revealed if it may identify the participants. The confidentiality of any patients identified throughout the interviews will also be protected.

All tapes and transcribed data will be held in a secure environment accessed by the principal researcher only. If you do not wish to participate or would like to withdraw consent at any stage of the research study, this will be accepted without question and will not affect the ongoing interaction between the researcher and participants.

Thank you for your time in reading this information.

If you have any questions or concerns in regards to this project please contact:

Ms Joanne Siffleet

Clinical Nurse
Centre for Nursing Research
SCGH, Nedlands, Perth
Ph: 9346 3174
email: Joanne.Siffleet@health.wa.gov.au

Supervisor: Dr Anne Williams
Research Fellow
Centre for Nursing Research, SCGH, Nedlands, Perth
Ph: 9346 3140
E mail: anne.williams@curtin.edu.au

Supervisor: Dr Pat Rapley
Research Associate
Centre for Nursing Research, SCGH, Nedlands, Perth
Ph: 9346 2682
E mail: P.Rapley@curtin.edu.au

If you have any concerns or complaints about the research project and wish to talk to an independent person, you may contact:

Research Ethics Officer
Human Research Ethics Officer
Curtin University of Technology
Ph: 9266 2784
Email: hrec@curtin.edu.au

or

The Administrative Officer
Human Research Ethics Committee
Sir Charles Gairdner Hospital
Ph: 9346 2999

APPENDIX B

STAFF CONSENT FORM

Maintaining Emotional Wellbeing in the Intensive Care Unit: A Grounded Theory

Study from the Perspective of Experienced Nurses

Investigators: Joanne Siffleet, Dr Anne Williams and Dr Pat Rapley

Subject name: _____ Date of birth: _____

- 1** I have been given clear information (verbal and written) about this study and have been given time to consider whether I wanted to take part.
- 2** I have been told about the possible advantages and risks of taking part in the study and I understand what I am being asked to do.
- 3** I know that I do not have to take part in the study and that I can withdraw at any time during the study without affecting my future employment. My participation in the study does not affect any right to compensation, which I may have under statute or common law.
- 4** I agree to take part in this research study and for the data obtained to be published provided my name or other identifying information is not used.

Name of participant:	Signature of participant:	Date
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Name of Investigator	Signature of Investigator	Date
----------------------	---------------------------	------

The Sir Charles Gairdner Hospital Human Research Ethics Committee has given ethics approval for the conduct of this project. If you have any ethical concerns regarding this study you can contact the secretary of the Sir Charles Gairdner Hospital Human Research Ethics Committee on telephone number 08 9346 3528.

APPENDIX C

INTERVIEW GUIDE

How would you define emotional wellbeing?

Tell me about a situation at work that you felt impacted on your emotional wellbeing positively?

Tell me about a situation at work that you felt impacted on your emotional wellbeing negatively?

What did you do in those situations?

What do you feel helped you in that situation? (prompts-colleagues, managers, family and friends, the environment you work in, shift you were on, counselling at work, private)

What do you feel hindered you in that situation? (prompts-colleagues, managers, family and friends, the environment you work in, shift you were on)

Is there anything that you do to protect your emotional wellbeing?

Is there anything about you personally that you feel affects the way that you manage your emotional wellbeing?

Is there anything else that you would like to say?

APPENDIX D

DEMOGRAPHIC INFORMATION

Gender:

Female ☐

Male: ☐

Age: _____ yrs

Clinical Position: _____

Length of time in ICU: _____

Shifts 8 hour shifts ☐ 12 hour shifts ☐

Full time ☐ Part time ☐

ICU course: Certificate ☐ Graduate Certificate ☐

Hospital training ☐ University ☐

APPENDIX E

FIRST LEVEL ANALYSIS CODES

- 1 Happiness
 - Anything referring to feeling happy or good.
- 2 People who you work with
 - Colleagues
- 3 Friends
 - Either people at work or out of work who were considered friends.
- 4 Morale
 - The mood of the unit.
- 5 Downtime at work
 - Downtime at work.
- 6 Talking/chatting at work
 - Chatting/socialising at work.
- 7 Management
 - Nursing management within the ICU.
- 8 Unsettled/isolation
 - Any descriptions indicating feeling isolation or unsettled.
- 9 Had enough
 - Fed up or exasperated
- 10 Looking after sick/unsick patients
 - Patients who were deemed ready medically to transfer to a ward or were not critically ill but needed ongoing respiratory support. ICU nurses in this study commonly referred to these patients as 'unsick' sick patients.
- 11 Junior medical staff
 - Junior medical staff such as residents or junior registrars who were rotating through ICU.
- 12 Dangerous work practices
 - Situations that nurses thought were unsafe for patients.
- 13 Compromising patient care
 - Actions described as affecting patient care adversely.
- 14 Consultant back-up/affirmation
 - Situations where nurses had sought the back up of consultants that was to do with patient treatment orders.
- 15 Recognition from medical staff
 - Acknowledgement of nursing actions from doctors.
- 16 Teamwork
 - Any reference to working in a team or descriptions of teamwork.
- 17 Bullying
 - Instances of bullying by other nurses, other staff.
- 18 Nursing hierarchy
 - Any reference to junior/senior nurse relationships
- 19 Credibility
 - Nurses having credibility as ICU/advance skill experts.
- 20 Mutual respect
 - Any references about respect from other nurses, medical staff, patients or families.

- 21 Offloading on colleagues
 - Complaining to or sharing problems with colleagues.
- 22 Outside interests
 - Activities undertaken by the nurse outside of work.
- 23 Culture of ICU
 - Any references to cultural beliefs, practices or attitudes within the ICU nursing staff.
- 24 Frustration
 - Any descriptions or references to frustration experienced by the nurse.
- 25 Patient stereotypes
 - Nurses had expectations in regard to patients and how each type of patient would be cared for and respond.
- 26 Take a breath
 - Relief of tension following caring for a patient when the atmosphere was emotionally distressing.
- 27 Requesting patients
 - Requesting to be assigned to a particular patient for the shift.
- 28 One to one nursing care
 - Any references to the patient/nurse ratio in ICU which was one nurse assigned to care for each patient.
- 29 Making patients better
 - Any reference where nursing care was described as improving the patient's condition.
- 30 Quality care/expert care/best care
 - References to expert nursing care, best care practices.
- 31 Caring for relatives
 - Any references to nursing care of families of the patient.
- 32 Managing complex issues
 - References to advance nursing skill or managing complex situations with patients and family.
- 33 Satisfaction
 - Any references to feelings of satisfaction from work.
- 34 Clinical expert
 - Descriptions of ICU nurse experts.
- 35 Achieving patient-centred goals
 - Setting patient goals that were achieved.
- 36 Teaching/nurturing
 - Teaching other/junior nurses.
- 37 Professional recognition
 - Anything to do with earning recognition, respect, professional and social from peers, patients, families or friends.
- 38 Washing and basic nursing care
 - References of performing nursing care duties such as washing and grooming.
- 39 Love work
 - Descriptions of enjoying work.
- 40 Conflict between senior medical staff
 - References to senior staff not agreeing on patient care and nurses powerless to intervene.

- 41 Powerlessness/loss of control
 - Feelings of powerlessness to change outcomes for patients or have a say in a patient's treatment.
- 42 Belief in medical staff
 - References that indicated nurses trusted medical staff.
- 43 Young patients dying
 - Nurses talking about the impact of younger patients dying in ICU.
- 44 Familiar patients dying
 - Descriptions of patients who had been in ICU for prolonged periods.
- 45 Self-harm patients
 - Anything to do with patients that had been admitted due to illness, injuries or conditions that were deemed to be self-inflicted or due to their own neglect
- 46 Reflection
 - References that directly stated that nurses reflected on their own or with colleagues about ICU.
- 47 Grieving
 - Anything where nurses indicated they experienced feelings of grief.
- 48 Dignity and respect
 - References of how nurses should treat patients in ICU.
- 49 Advocacy
 - Any reference where the nurse had acted on behalf of the patients interests to protect the patient.
- 50 Rapport with family
 - Descriptions of the relationships with families.
- 51 Composure/holding it together
 - Anything to do with the nurse controlling emotions.
- 52 Sadness
 - Descriptions of where the nurses acknowledged feelings of sadness caring for a patient/family in ICU.
- 53 Connecting/not connecting with families
 - References to the relationships achieved with families.
- 54 Respect for patients
 - References to the rights of the patient and how they should be treated.
- 55 Recognising own limitations
 - Descriptions of where the nurses understood their abilities to lie.
- 56 Anger
 - References to events in ICU that caused the nurse to feel angry.
- 57 Searching for meaning
 - Descriptions of where nurses struggled to understand the reasons for the patient's admission, as in sudden trauma or self-harm. Perceptions of unfairness for the patient and their family.
- 58 Learning/self-development
 - References to nurses education, formal or on the job.
- 59 Variety of work
 - Anything where nurses stated that they liked the variety of work in ICU, the different types of patients that came in.
- 60 Identifying with patients/relatives

- Where nurses drew similarities between themselves and the patient, for example same age, or kids the same age.
- 61 Handing over
- References to handing on the patient to the next shift, patient care was 24 hour job and things weren't left until the next day.
- 62 Working closely with colleagues
- References to physical layout of ICU and high staff numbers.
- 63 Remove self from emotional distress
- Avoiding patients or families that are potentially upsetting due to specific circumstances.
- 64 Talking with own family/friends
- References where nurses said they talked to family and friends about the difficult things in ICU.
- 65 Staff attitudes
- Anything where nurses described attitudes of colleagues.
- 66 Distraction from sad things
- References to nurses said they tried to distract themselves from thinking about sad things.
- 67 Accomplishment
- Anything where nurses described a sense of accomplishment.
- 68 Exercise
- Any exercise activities away from work that nurses said helped their emotional wellbeing.
- 69 Predictability
- References to things that were predictable.
- 70 Work/life balance
- Anything that indicated nurses tried to achieve a balance between work and home-life.
- 71 Alcohol
- When nurses stated that they used alcohol to help get over their emotions.
- 72 Caring for colleagues
- Any statements where nurses said they looked out and cared for each other.